2005

Comprehensive Performance Report:

Commercial HMOs and Their POS Plans in Maryland

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TABLE OF CONTENTS

INTRODUCTION

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Overview

The Maryland Health Care Commission (MHCC) is committed to assessing and reporting the performance of Maryland commercial health maintenance organizations (HMO) and point of service (POS) plans. The *Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland (Comprehensive Report)* is MHCC's ninth annual report on the performance of HMOs operating in Maryland. This report will provide plans, providers, researchers, and other interested individuals with detailed, plan-specific and Maryland-wide indicators of performance.

This year's *Comprehensive Report* incorporates data collected in 2005 from the Health Plan Employer Data and Information Set (HEDIS®[1]) measurement tool, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) 3.0H survey, and results for 2003 and 2004. The performance measures in this report cover clinical quality, member satisfaction, plan descriptive features, and utilization information. Additionally, results for measures specific to Maryland are also found in this report.

Reporting multiyear performance builds a stronger depiction of how a plan carries out health care delivery. Single year results provide a snapshot and should be viewed in that context. Results tables included here illustrate changes in plans' absolute (actual) rates and relative (comparative) rates. Additionally, MHCC conveys the designation of "Star Performer" as an acknowledgment of dedication to quality health care delivery to any plan achieving rates statistically higher than the Maryland average for the three recent reporting years (2003–2005).

The *Comprehensive Report* is designed to assist plans, purchasers, and policy makers in assessing the relative quality of services delivered by plans licensed to operate in Maryland. Such information has the capacity to affect purchasing and enrollment decisions, marketplace changes, and quality initiatives implemented by commercial HMOs and POS plans.

Report Organization

The *Comprehensive Report* organizes measurement results into groups, or domains, of related information. The sequence of measures within the domains is similar to the order of the measures identified in *HEDIS 2005, Volume 2: Technical Specifications*. Maryland plans followed the technical specifications in developing their rates.

Plans are listed alphabetically in tables that display their rates and the average rate for all Maryland plans for HEDIS, the CAHPS 3.0H survey, and MHCC-specific measures of performance.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

The *Comprehensive Report* progresses from a summary of plans' performance into detailed results for each measure. A description of the sections follows.

- **Summary of Performance** provides an overview of the Maryland marketplace and the performance of the plans required to report to MHCC.

- **Methodology** covers data sources, statistical methods, and general considerations for interpreting the data in this report.

- **Measure Performance** organized by the HEDIS domain, provides the following for each measure:
  - **Background** information describing a measure's importance and any relevant clinical or population health information;
  - **Measure definitions** consistent with *HEDIS 2005, Volume 2: Technical Specifications*;
  - **Data collection methodology** indicating if the administrative, hybrid, or survey methodology was used to collect the measure;
  - **Summary of changes** listing the significant changes in measure specifications that may affect the ability to trend results;
  - **Star Performer** identifying the measures eligible for the designation;
  - **Notes** describing any considerations regarding the production or interpretation of results (where applicable);
  - **Results** of plan rates and scores that identify salient results; and
  - **Data Table(s)** containing plan rates (i.e., percentages, rates per 1,000 members), significant changes in rates from 2003 to 2005, and relative rates (i.e., designation above, equivalent to, or below the Maryland HMO/POS average) for the past three years.

- **External Accreditation & Financial Ratings** presents the accreditation status and financial rating of each plan. In Maryland, accreditation is voluntary (i.e., not required by law). Information on the various organizations that accredit managed behavioral healthcare organizations (MBHO) is included in this section as well. The material presented in this section concludes with ratings reported by A.M. Best on plans' financial stability.

- **Appendix A: Health Plan Performance by Measure** sorts plan results by score for each measure to show which plans performed best in each category of care.

- **Appendix B: Methods for Data Analysis** describes the methodology used in comparing plan performance and comparing rates across years for HEDIS and CAHPS 3.0H survey measures.

- **Appendix C: Methodology for Audit of HEDIS 2005 Rates for Maryland HMOs & POS Plans** summarizes the 2005 audit methodology used in verifying that Maryland health plans followed the specifications of the NCQA HEDIS Compliance Audit™[3] when calculating the rates for each measure.

- **Appendix D: Methodology for Administering CAHPS 3.0H Survey Results for Maryland HMOs & POS Plans** summarizes the survey methodology used in collecting and calculating the CAHPS 3.0H 2005 survey results.

MHCC-specific measures are included in the *Behavioral Health* section. These descriptive and performance indicators were recommended by the Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations and MHCC. They are part of the set of mandatory performance measures that commercial HMOs in Maryland were required to report in 2005.

Companion HMO and POS Performance Reports

Measuring the Quality of Maryland HMOs and POS Plans: 2005 Consumer Guide provides a subset of measures selected for their interest to a broad audience.

Measuring the Quality of Maryland HMOs and POS Plans: State Employee Guide, spring edition, presents the same content and format as the *2005 Consumer Guide* but includes only HMOs and POS plans available to employees of the State of Maryland.

In January 2006, MHCC will release the ninth annual *Maryland Commercial HMOs & POS Plans: Policy Issues.* This report summarizes the aggregate performance of Maryland plans and compares it to commercial plans in the region and nation.

Other Performance Reports

In consultation with the Department of Health and Mental Hygiene and the Department of Aging, MHCC produces the *Maryland Nursing Home Performance Evaluation Guide,* which contains comparative data that consumers can use to evaluate Maryland nursing homes. The *Hospital Performance Evaluation Guide* is another interactive guide that MHCC publishes that features both descriptive information and quality measurement results on the performance of Maryland's acute care hospitals. MHCC also produces the *Maryland Ambulatory Surgery Facility Consumer Guide,* which allows consumers to compare descriptive information about these facilities and their services. All of the guides are accessible through the MHCC Web site at http://mhcc.maryland.gov/consumerinfo/.

[3] HEDIS Compliance Audit™ is a registered trademark of NCQA.

About MHCC

MHCC is a public regulatory agency whose members are appointed by the Governor, with the advice and consent of the Maryland Senate. Maryland law, Health General Article, Section 19-135 (c) charges MHCC with establishing and implementing a system to comparatively evaluate the quality of care and performance of HMOs on an objective basis. The purpose of the system is twofold:

1. Assist HMOs in improving quality of care by establishing a common set of performance measures; and
2. Disseminate the findings of the performance measures to consumers, purchasers, HMOs, and other interested parties.

In addition to its mandate to assess and report on the quality of commercial HMOs, nursing homes, hospitals, and ambulatory surgical facilities, MHCC also has the following responsibilities:

- develop a comprehensive standard health benefit plan for small employers;
- create a database of non-hospital health care services;
- adopt a state health plan to guide certificate of need decisions;
- implement a certificate of need program for certain health care facilities and services; and
- oversee electronic claims clearinghouses.

METHODOLOGY

METHODOLOGY

This section provides descriptive information about the data and statistical methods used to determine relative plan performance, the statistical significance of trends, and further details on the criteria used to identify Star Performers. Finally, general considerations regarding interpretation of data contained in this report address the factors that potentially impact plan results.

Data Sources

Information in the *Comprehensive Report* is drawn primarily from two sources: HEDIS performance measures and CAHPS 3.0H survey results. In addition, to satisfy legislative, task force, and MHCC requirements, plans report on several measures of performance specific to Maryland, referred to as "MHCC-specific" measures.

HEDIS Measures

HEDIS is a standard set of performance measures developed by NCQA and experts representing many fields. NCQA is a not-for-profit organization that assesses, accredits, and reports on the quality of managed care organizations, including health maintenance organizations.

Rates for HEDIS 2005 measures in this report reflect services delivered during the 2004 calendar year. Similarly, 2004 and 2003 results presented in this report for trending purposes reflect performance experiences from calendar years 2003 and 2002, respectively.

Based on the State of Maryland's information needs and expectations regarding the reliability of data, MHCC required that plans report a total of 42 HEDIS measures for calendar year 2004. Several measures required collecting multiple rates; for example, the Childhood Immunization measure has two combinations of recommended immunizations, thereby resulting in two separate rates for one measure. In addition, Maryland plans were asked to provide specific data and information about their behavioral health services.

This report presents results collected from seven plans by the State of Maryland in seven general areas, grouped similarly to the NCQA HEDIS domains of care as follows:

1. Effectiveness of Care
2. Access/Availability of Care
3. Satisfaction With the Experience of Care (CAHPS 3.0H survey results)
4. Use of Services
5. Behavioral Health Care
6. Health Plan Descriptive Information
7. Health Plan Stability

All HEDIS measures collected by plans for MHCC have been audited according to the certified audit program established by NCQA. The NCQA HEDIS Compliance Audit is a standardized methodology that enables organizations to directly compare plans' rates for HEDIS performance measures. The audit is a two-part process, consisting of an assessment of overall information systems capabilities followed by an evaluation of the plan's ability to comply with HEDIS specifications. HealthcareData.com, LLC, independently audited data displayed throughout this report under a separate, competitively-bid contract with the MHCC. See Appendix C for more information regarding the audit process.

Data Collection Methodology

For many measures, HEDIS gives plans the choice of administrative or hybrid data collection methodologies. The hybrid methodology allows health plans that do not adequately capture health care encounters in their administrative data systems to calculate rates that better reflect actual performance. For this project, the majority of measures in the *Effectiveness of Care* domain and the Well-Child Visit measures allow health plans to use either methodology. Plans must use the administrative method to collect data for Use of Appropriate Medications for People With Asthma, Follow-up After Hospitalization for Mental Illness, and Antidepressant Medication Management measures.

Briefly, the two methodologies entail the following steps:

- ***Administrative methodology:*** After identifying the eligible member population for a measure, health plans search their administrative database (claims and encounter systems) for evidence of the service. For some measures, rates calculated based on the administrative method can be slightly lower compared to rates calculated for the same measure using the hybrid method. Plans may choose this method because it is easier to produce rates.

  In the results tables for hybrid-eligible measures, plans that use only administrative data to generate their rate are indicated by a superscript "m."

- ***Hybrid methodology:*** The hybrid methodology allows health plans to augment their HEDIS calculations with information gathered from medical records. First, a plan selects a random sample of eligible members for a measure. Next, the plan searches its administrative databases for information about whether each individual in the sample received the service. If the administrative database does not contain the evidence needed, then the plan consults the medical records for evidence that the remaining individuals in the sample received the service.

Rotation of Measures

NCQA allows health plans to *rotate* data collection for selected HEDIS measures. For rotated measures, data may be collected once and reported for two consecutive years. The measures that NCQA selects for rotation are those that impose a substantial burden for health plans to collect and have been part of the HEDIS measurement set for at least two years, and for which no significant changes have been made on how data are collected and reported.

If a health plan chooses to rotate a measure, valid results reported to MHCC in 2004 for the measure are also shown as 2005 results in this report. Table 1 indicates the measures eligible for rotation and the measures each plan chose to rotate.

Table 1: Rotated Measures

Health Plan	Childhood Immunization Status	Adolescent Immunization Status	Beta-Blocker After a Heart Attack	Cholesterol Management After Acute Cardiac Event	Well Child Visits-First Fifteen Months of Life	Well Child Visits-Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care
Aetna			Yes				
BlueChoice							
CIGNA	Yes		Yes				
Coventry	Yes	Yes	Yes	Yes			
Kaiser		Yes	Yes	Yes	Yes	Yes	Yes
M.D. IPA						Yes	Yes
OCI						Yes	Yes

Plans that chose to rotate the measure are identified by a superscript "r" in the results tables.

"Not Report" and "Not Applicable" Designations

According to NCQA guidelines, during a plan's HEDIS Compliance Audit, measures are assigned a "Not Report" (denoted by NR) designation if:

- The plan did not calculate the measure and a population existed for which the measure could have been calculated.
- The plan calculated the measure but chose not to report the rate.
- The plan calculated the measure but the rate was materially biased.[4]

Plans must report a rate for each measure included in MHCC's performance reporting set and do not have the option of choosing not to calculate or not report the rates for these measures. Therefore, each NR designation that appears in the Maryland HMO performance reports means the plan did not pass the audit for that measure.

When a plan can accurately generate a rate but the denominator of the rate (the number of members who meet criteria for a measure) is less than 30, its rate will be reported as "Not Applicable" (NA). NCQA guidelines set 30 as the lower acceptable limit for denominators. When fewer than 30 people constitute the unit undergoing comparison, statistical validity, as well as meaningfulness of the measurement, becomes questionable.

[4]For measures reported as a rate (e.g., Effectiveness of Care measures) and for the three service measures, materially biased is any error that causes a (+/-) 5 percentage point difference in the reported rate. For nonrate measures (e.g., Use of Services and survey measures), materially biased is any error that causes a (+/-) 10 percent change in the reported rate.

CAHPS 3.0H Survey Measures

Consumers' experiences with their health care and health plans are also important measures of performance used to monitor quality. Collaboration between NCQA and the Agency for Healthcare Research and Quality (AHRQ) resulted in the convergence of the former NCQA Standardized Member Satisfaction Survey and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Note: *CAHPS originally stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the name has changed to capture the full range of survey products and tools.*

The *Satisfaction With the Experience of Care* section of this report contains survey results from health plan members. The CAHPS 3.0H survey (included in the HEDIS measurement set) has been administered to randomly-selected samples of Maryland commercial HMO members each year since 1999.

Various versions of the CAHPS survey have been created—adult and child versions, as well as product specific surveys for commercial, Medicaid, and Medicare health plan members. All versions of the survey contain question sets covering such topics as enrollment and coverage, access to and utilization of health care, communication and interaction with providers, interaction with health plan administration, self-perceived health status, and respondent demographics.

MHCC contracted with The Myers Group to administer the CAHPS 3.0H survey to the adult, commercial HMO population. The Myers Group is an NCQA-Certified CAHPS 3.0H survey vendor. A random sample of 1,100 members from each health plan was surveyed in 2005. The survey was administered according to the protocol outlined by NCQA in *HEDIS 2005, Volume 3: Specifications for Survey Measures*. See Appendix D for additional information regarding the survey methodology.

Statistical Analysis

Calculation of Relative Performance Categories

Performance categories that classify a plan's performance on each measure as above average, average, or below average were assigned by comparing each plan's rate to the unweighted average rate of all seven Maryland plans. Each plan contributed equally to the average rate (i.e., the average rate was determined by adding the rate for each plan and dividing by seven). If the difference between the plan's rate and the Maryland HMO/POS average was statistically significant, the plan was assigned to the above- or below-average category, accordingly. To determine if the difference was statistically significant, the analysis used a modified t-test that accounted for the error in measurement of the individual plan's rate as well as the error in measurement of the Maryland HMO/POS average. A 95 percent degree of confidence was then used to determine if the difference between the rates was statistically significant. Appendix B provides a more detailed description of this methodology.

The tables in this report use the following symbols to denote relative comparisons:

● = Plan performed significantly better than the Maryland HMO/POS average.

⊙ = Plan performed equivalent to the Maryland HMO/POS average.

○ = Plan performed significantly worse than the Maryland HMO/POS average.

The plan members who are considered eligible for a specific service are those who meet the qualifying criteria identified by each HEDIS measure, as described in *HEDIS 2005, Volume 2: Technical Specifications*.

Plans that use the administrative method to calculate a rate tend to have smaller confidence intervals around their rates, since the entire population eligible for the measure is used as the measure denominator rather than a sample. A larger denominator allows a more precise estimate of the true rate. In statistical terms, the confidence interval around the rate is smaller. *This means that two plans with the same percentage can be in two different performance strata.* For example, Plan A and Plan B both report a rate of 85 percent for a particular measure. The Maryland HMO/POS average for this example is 80. Plan A used the hybrid method and, due to its larger confidence interval, its performance is designated as "average" when compared to the state average for all seven plans. However, Plan B used the administrative method and its performance is designated as "above average" since its narrower confidence interval excludes the Maryland HMO/POS average. Additionally, plans with the same rate could be designated as performing at two different levels because **statistical tests were conducted using entire numbers without rounding**. Rates were rounded for display in this report.

Calculation of Changes from 2003 to 2005

The trending tables contain a column titled "Change 2003–2005". This column indicates if a change in a plan's actual rate from 2003 to 2005 is statistically significant and, if so, the direction of the change. It is an indicator of the consistency of a plan's performance over time rather than its performance in relation to other plans.

The tables use the following symbols:

🡅 = Plan rate increased significantly from 2003 to 2005.

⇔ = Plan rate *did not* change significantly from 2003 to 2005.

🡇 = Plan rate decreased significantly from 2003 to 2005.

This indicator shows whether a plan's actual rate has improved over time, and is independent of the plan's relative rating. For example, a plan's rate may have changed from 65 percent in 2003 to 75 percent in 2005, a significant increase that would be identified with the "🡅" symbol. However, if the Maryland HMO/POS average changed—for example, from 60 percent in 2003 to 80 percent in 2005—the plan's relative rating may have been above average in 2003 but below average in 2005 (i.e., even though its actual rate increased significantly, it increased less significantly than the Maryland HMO/POS average over the same period).

The three columns labeled "Comparison of Relative Rates" show how each plan performed in relation to the other plans that reported each year. The relative score is an indicator of the plan's performance (above, average, or below) relative to the Maryland HMO/POS average.

Note: *The state average for 2003 includes eligible plans in operation at that time required to submit performance results to MHCC. Therefore, the Maryland average for 2003 results includes values that do not currently appear in this year's report. This report includes performance details for only those plans currently operating in Maryland and meeting certain criteria.*

The term "significant" is used in the statistical sense; for example, a significant change in a plan's rate from 2003 to 2005 means that the change is very unlikely to have occurred due to chance variation. It does not describe, however, the magnitude of that change. A one percent change can be considered significant if the population on which it is based is large, as is often the case with HEDIS rates calculated using the administrative method.

Percentiles

NCQA annually releases Quality Compass®[5], which contains HEDIS rates and averages that are obtained from hundreds of HMOs across the country. These data are used to construct scores by quartile and for the top (90th percentile) and bottom (10th percentile) deciles. A score in the top decile is a score that is higher than the scores of at least 90 percent of the HMOs that report to Quality Compass; a score in the bottom decile is a score that is lower than the scores of at least 90 percent of the Quality Compass scores.

Rates and averages that are in the top and bottom deciles in the *Use of Services* section of this report are indicated by the following symbols:

▲ = Plan rate is higher than 90 percent of other plans nationally.

▼ = Plan rate is lower than 90 percent of other plans nationally.

Star Performers

To be considered a Star Performer for a specific measure, a health plan must maintain an above average level of performance for each of the past three years, as identified by the statistical significance test described in the previous section. Only measures reported in the *Consumer Guide* are considered for Star Performer designation.

Twenty five measures: 17 HEDIS and 8 CAHPS were eligible for Star Performer status in 2005. The eligible measures follow:

HEDIS

- Childhood Immunization Status (Combination 2)
- Adolescent Immunization Status (Combination 2)
- Cervical Cancer Screening

[5] Quality Compass® is a registered trademark of NCQA

- Chlamydia Screening (Ages 16-25)
- Cholesterol Management After Acute Cardiovascular Event: Cholesterol Control <130mg/dL
- Comprehensive Diabetes Care:
  - Blood Glucose (HbA1c) Control
  - Cholesterol (LDL-C) Control < 130 mg/dL
  - Eye Exam Performed
  - Monitoring for Kidney Disease
- Use of Appropriate Medications for Asthma
- Well-Child Visits for Infants and Children: Combined age rate—Birth to15 months and 3–6 years
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness:
  - 7 days of discharge
  - 30 days of discharge
- Antidepressant Medication Management:
  - Treatment (Optimal Contacts)
  - 3 months
  - 6 months

CAHPS 3.0H

- Rating of Health Plan
- Recommending Plan to Friends/Family
- Few Consumer Complaints
- Health Plan Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Rating of Health Care

Star Performer information appears in the following places in this report:

- Table 4 ("Star Performers by Plan") in the *Summary of Performance* section lists the measures for which a plan has attained Star Performer status.
- In trending tables, asterisks (*) appear next to the plan name if the plan has been designated as a Star Performer for the measure.

General Considerations for Interpreting Information

Impact of Consolidations of Plans

The number of plans reporting to MHCC remained the same (seven plans) from 2004 to 2005. In 2003, a total of eight were included in calculating the Maryland HMO/POS average. Consolidation of the plans may impact a comparison of the Maryland HMO/ POS average between 2003 and 2005, especially if the plans that no longer report had rates that were much higher or lower than average. This happens because the method used to calculate the Maryland HMO/POS average is sensitive to changes in the number of plans when plans that perform better or worse than average combine or leave the market. In addition, the surviving plan has the option of counting members from the acquired plan for the measurement year in which the merger took place.

The Maryland HMO/POS average is calculated as a simple average of the rates of all commercial plans operating in Maryland during the reporting year. The average is not weighted by plan enrollment.

Data Completeness

A plan may not have complete data on all of the services rendered to its members for reasons described as follows.

- In plan mergers or acquisitions, the surviving health plan must integrate all data from predecessor plans for future HEDIS reporting. Administrative data system conversions can be complex and can lead to loss of data. Even if a system conversion has not taken place, creating HEDIS measures from multiple systems can raise data integration issues that may lead to data loss.
- For some HMO providers, payment is capitated and is not associated with each individual service rendered to enrollees; therefore, providers may not always submit the information to the HMO even though care was provided.
- Many HMOs do not receive complete patient data from contractual vendors who provide services such as laboratory, radiology, pharmacy, and mental health services. However, plans have improved data transfers from vendors by implementing incentive programs and setting this requirement as part of their contracts.
- Plans may not have data for some members because the employer contracted with a different company to provide certain services such as behavioral health care and pharmacy coverage. When a health plan contracts with another company or provider to deliver services, the health plan remains responsible for the care provided by its contractors and for data associated with provision of care.
- Plans may not always report all of the medical codes required for payment purposes. HEDIS measures rely on standard coding (e.g., ICD-9, CPT-4) to capture information on delivery of services from administrative data. The HEDIS coding requirements are indicated in *HEDIS 2005, Volume 2: Technical Specifications*. In some cases, plans create medical codes to represent certain services for billing purposes. Often these "home-grown codes" cannot be used to calculate the HEDIS rate in accordance with NCQA specifications. The federal Health Insurance Portability and Accountability Act (HIPAA) reduced plans' reliance on homegrown codes.

All of these factors, along with the choice of administrative versus hybrid data collection methods, can cause variation in HEDIS results that are not attributed to differences in performance. Although plans continually work to improve their data for use in performance measurement and quality improvement, demonstrating the effects of these factors on final HEDIS rates is extremely difficult.

Performance Measurement Issues

Methods for assessing health plan performance are continually under development. Each year, HEDIS measures are refined and new measures are added to create a reliable and valid means of evaluating health plan performance. Throughout this report, factors to consider when interpreting the results are highlighted, when applicable. In addition to differences in quality, the following issues can cause variation in HEDIS results:

- HEDIS measures collected using the hybrid or survey methodologies are calculated from samples of the plan population. Although sampling methods that plans use conform to statistical methods, there is still a small chance that the sample does not represent the underlying population. Although the likelihood of this random error occurring is small, the estimate obtained with a sample may produce a result that exceeds the error tolerance of 5 percent set by HEDIS specifications.
- Some measures in the *Effectiveness of Care* domain allow for optional exclusions. This means that MCOs are allowed to exclude certain members from the denominator if they are identified as having a certain procedure or comorbidity (e.g., women who have had bilateral mastectomies may be excluded from the Breast Cancer Screening measure). The MCO is not required to make these exclusions, but may do so to improve the accuracy of its rates.
- HEDIS results are not risk-adjusted, which may account for variation in rates for some HEDIS measures, such as measures in the *Use of Services* domain and Frequency of Selected Procedures measure. There may be differences in the plans' populations that cause variation of the rates even when the quality of the health care delivered is the same. For example, Plan A may have a sicker population than Plan B. Although both plans may provide the same quality of care, Plan A may have higher utilization rates for some services because their enrollees need more medical care than do the healthier members of Plan B. Results would not be due to differences in performance. Studies supported by AHRQ have shown differences in HEDIS rates due to education and economic differences in plan members. Better-educated members tend to demand and get better services.

SUMMARY OF PERFORMANCE

SUMMARY OF PERFORMANCE

This section provides an overview of trends in the managed care market and a summary of performance on the Maryland commercial HMOs required to report in 2005.

National Trends in Managed Care

- Nationally, health care insurance premiums have risen steadily over the years: 13.9 percent from 2002 to 2003; 11.2 percent from 2003 to 2004. To offset their health care expenses, employers often increase employees' share of the costs (deductibles, copayments, coinsurance). The trend in cost sharing continues in 2005, although to a lesser degree than in the past (Health Affairs, 2005).
- Enrollment in managed care plans (HMOs, PPOs, POS plans) nationally has risen dramatically, from 27 percent in 1988 to 95 percent in 2004. PPO enrollment has largely driven this growth, which rose from 11 percent in 1988 to 55 percent in 2004. HMO enrollment has been less consistent, increasing to 31 percent in 1996 but decreasing to 25 percent in 2004. The shift from traditional managed care (HMOs) to PPOs may reflect consumers' preferences for fewer restrictions on access to care (Kaiser Family Foundation, 2004).
- Rising costs and movement toward simpler access have led employers and plans to encourage consumers to become more involved in their health care. This means they must be more knowledgeable, accountable, and active in managing their care. As active partners in their health care, consumers will:
  - use their health care benefit dollars wisely by choosing cost-effective services and quality providers;
  - take control of their health care needs by actively seeking information about conditions and participating in risk-management programs;
  - make informed decisions about care and consider the resources needed to provide that care; and
  - gain confidence in their decisions (Mercer, 2004).
- The growth rate of health insurance premiums declined for the second straight year, slowing to 9.2 percent increase in 2005, but it is still more than three times the growth in works' earnings and two and a half times the rate of inflation. In addition, the percentage of all firms offering health benefits to their employees has fallen significantly from 69 to 60 percent over the last 5 years (Kaiser Family Foundation and Health Research and Educational Trust, 2005).

Maryland Health Plans in this Report *(see Table 2)*

HMOs that primarily serve the commercially-insured population and receive over one million dollars in Maryland premiums are included in this report. Each plan has the option of reporting combined performance results for its HMO and POS products, but only if the POS plan operates under the license of its HMO. Each plan (with the exception of Kaiser Permanente) has chosen that option. **References to HMOs and HMO members throughout this report should be understood to include references to POS members for six of the seven plans.** The number of plans reporting to MHCC remained the same for 2004 and 2005.

Table 2 shows the number of members in each health plan enrolled in 2004. Also shown is the percentage of members who chose to enroll in the plan's HMO product and the percentage that chose to enroll in the plan's POS product. POS products tend to cost more, which may explain why fewer people selected the POS product.

Table 2: Maryland Health Plan Enrollment, 2004

Health Plan	Number of Plan Members	% of Members Enrolled in HMO	% of Members Enrolled in POS
Aetna Health Inc.-Maryland, DC, and Virginia **(Aetna)**	337,317	87%	13%
CareFirst BlueChoice, Inc. **(BlueChoice)**	494,693	56%	44%
CIGNA HealthCare Mid-Atlantic, Inc. **(CIGNA)**	152,160	66%	34%
Coventry Health Care of Delaware, Inc. **(Coventry)**	97,586	89%	11%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. **(Kaiser Permanente)**	444,088	97%	3%
MD-Individual Practice Association, Inc. **(M.D. IPA)**	243,659	85%	15%
Optimum Choice, Inc. **(OCI)**	521,886	82%	18%

Below is a brief overview of the plans' operating structure:

- **Aetna** and **CIGNA**, for-profit HMOs, and **Kaiser Permanente**, the only non-profit HMO operating in Maryland, represent national health care insurers in Maryland.
- **BlueChoice,** a for-profit HMO, operates under a holding company called CareFirst.
- **Coventry,** a for-profit HMO, is a regional company.
- **M.D. IPA** and **OCI**, for-profit HMOs, are subsidiaries of Mid Atlantic Medical Services, LLC (MAMSI), a wholly owned subsidiary of UnitedHealth Group, Inc.

One-Year Above-Average Performance *(see Table 3)*

Table 3 displays the number of instances by domain for which each plan scored above average. Based on reported rates used to calculate 2005 rankings, plans have the potential to achieve above-average rankings on 49 HEDIS and 8 CAHPS measures. Kaiser Permanente received the most above-average scores. This plan achieved this level for more than half of the measures, followed by Coventry and M.D. IPA with 16 each, and BlueChoice with 14 above-average scores. Both CIGNA and OCI had 10 above-average scores with Aetna having the fewest above-average scores, achieving this level of performance 16 percent of the time.

BlueChoice reports that rate increases above those reported in 2004 reflect improvements in data collection, enhancements to the disease management program, and actual measure specification changes.

As a general rule, composite rankings have been used to summarize plans' performance; therefore, the number of eligible measures is sometimes less than the number of total measures in each domain. Results for the individual measures in a composite are excluded from a plan's total count. For example, the Childhood Immunization Status (Combination 2) measure counts as one measure; the results for each antigen are not counted individually. For the Use of Appropriate Medications for People With Asthma measure, two age stratifications (ages 5-17 and ages18-56) were included in the above average calculation since they were reported in the *Consumer Guide*.

Table 3: Total Above-Average Scores by Plan

Total Above Average Scores by Plan, 2005								
	Effectiveness of Care	Access/ Availability of Care	Behavioral Health	Health Plan Descriptive Information	Health Plan Stability	Total HEDIS	Total CAHPS	Total HEDIS & CAHPS
Total Number of Measures in Each Domain:	28	9	7	4	1	49	8	57
Aetna	2	2	2	2	1	9	0	9
BlueChoice	5	5	3	0	1	14	0	14
CIGNA	4	5	0	0	1	10	0	10
Coventry	2	7	0	2	1	12	4	16
Kaiser Permanente	15	5	5	4	0	29	1	30
M.D. IPA	7	1	3	1	1	13	3	16
OCI	5	0	2	1	1	9	1	10

See *Appendix A: Health Plan Performance by Measure* for the measures that are included in each domain.

Three-Year Above-Average Performance—Star Performers *(see Table 4)*

The designation of Star Performer is given to plans that have maintained above-average performance on a given measure for each of the past three years. Plans could potentially achieve this status for 25 measures: 17 HEDIS and 8 CAHPS measures. Only measures reported in *Measuring the Quality of Maryland HMOs and POS Plans: 2005 Consumer Guide* are eligible for this designation. In 2005, Coventry, Kaiser Permanente, and M.D. IPA received at least one Star Performer designation. Kaiser Permanente achieved this status for 40 percent of the eligible measures. Four plans—Aetna, BlueChoice, CIGNA, and OCI—did not achieve Star Performer status. For more information on the measures that qualify for Star Performer designation, see the *Methodology* section.

Table 4: Star Performers by Plan

Plan	Number of Star Performer Designations	Measures for which Plan Achieved Star Performer Status
Aetna	0	
BlueChoice	0	
CIGNA	0	
Coventry	4	• Getting Needed Care • Getting Care Quickly • Rating of Health Care • Well-Child Visits for Infants and Children
Kaiser Permanente	10	• Recommending Plan to Friends/Family • Immunizations for Children • Immunizations for Adolescents • Screening for Chlamydia • Comprehensive Diabetes Care – Cholesterol Control – Eye Exams – Monitoring for Kidney Disease • Antidepressant Medication Management – Monitoring (3 months) – Monitoring (6 months) • Follow-Up After Hospitalization (7 Days)
M.D. IPA	4	• Rating of Health Plan • Recommending Plan to Friends/Family • Health Plan Customer Service • Antidepressant Medication Management Treatment (Optimal Contacts)
OCI	0	

Note: *Measure names used in the above table correspond to those used in the Consumer Guide. Measure names used elsewhere in the Comprehensive Report correspond to those used in HEDIS Volume 2: Technical Specifications.*

EFFECTIVENESS OF CARE

EFFECTIVENESS OF CARE

Overview

This section contains results for the HEDIS *Effectiveness of Care* measures that MHCC required Maryland commercial HMOs to report in 2005. These measures, listed below, are designed to illustrate a plan's delivery of clinical services in accordance with established and widely accepted guidelines. *Effectiveness of Care* measures indicate the percentage of people who should have received a service actually did receive the service. For all of the measures presented in this section, higher rates indicate better performance.

Measures in Domain

- Childhood Immunization Status
- Adolescent Immunization Status
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Chlamydia Screening in Women
- Controlling High Blood Pressure
- Beta-Blocker Treatment After a Heart Attack
- Persistence of Beta-Blocker Treatment After a Heart Attack (new measure)
- Cholesterol Management After Acute Cardiovascular Event
- Comprehensive Diabetes Care
- Use of Appropriate Medications for People With Asthma
- Flu Shots for Adults Ages 50-64
- Colorectal Cancer Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Medical Assistance with Smoking Cessation

The measures Follow-Up After Hospitalization for Mental Illness and Antidepressant Medication Management in the HEDIS *Effectiveness of Care* domain are included in the *Behavioral Health* section of this report.

Measures Eligible for Rotation

- Childhood Immunization Status
- Adolescent Immunization Status
- Beta-Blocker Treatment After a Heart Attack
- Cholesterol Management After Acute Cardiovascular Events

Plans that chose to rotate any of these measures are identified by a superscript "r" in the results tables.

CHILDHOOD IMMUNIZATION STATUS

Background

Immunization has enabled the global eradication of smallpox, the elimination of poliomyelitis from the Western hemisphere, and major reductions in the incidence of other vaccine-preventable diseases in the United States. Vaccines are one of medicine's best examples of primary prevention proven to help children stay healthy and avoid potentially harmful effects of childhood diseases such as mumps and measles. According to the Centers for Disease Control and Prevention (CDC), 10.5 million cases of illness and 35,000 deaths are prevented each year in the United States due to childhood immunizations. In 2003, over 79 percent of infants and toddlers in the United States were vaccinated before their third birthday. Maryland's rate was 81 percent, slightly higher than the national rate (CDC, 2003).

Although the incidence of preventable childhood diseases has declined due to high rates of vaccination in school-age children, many children do not receive sufficient immunization to meet recommended guidelines. In 2003, as in previous years, urban areas with high concentrations of people from the lower socio-economic strata reported lower immunization rates (CDC, 2004). Misconceptions regarding vaccination of children also influence parents' decisions. Parents who have never seen an outbreak of these diseases or who believe the diseases are no longer present in today's society may not be willing to obtain immunizations for their child. While others may feel that side effects or risk of illness may outweigh the risk of disease. Together these factors can lead to children not receiving the proper vaccines (CDC, 2004).

Before age two, every child should be immunized against 12 potentially serious vaccine-preventable diseases: measles, mumps, rubella, diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenza* type b (Hib disease), hepatitis B (Hep B), varicella (chickenpox), pneumococcal disease, and influenza. At least one shot is needed for each of these diseases, and for a few diseases, several doses are needed for the best protection. Vaccines are given at this early age because the diseases they prevent are far more serious or common among babies or young children. Up to 60 percent of severe disease symptoms caused by Hib in children are among babies under 12 months of age. Moreover, 90 percent of all deaths from whooping cough are among children under six months of age (The Sabin Vaccine Report, 2005).

The following is a schedule of immunizations recommended as of December 2004 by the CDC, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians.

Recommended Childhood Immunizations

Age	DTaP/ DT	IPV	MMR	Hep B	HiB	VZV	PCV
Birth–2 months				✓			
1–4 months				✓			
2 months	✓	✓			✓		✓
4 months	✓	✓			✓		✓
6 months	✓				✓		✓
6–18 months		✓		✓			
12–15 months			✓		✓		✓
12–18 months						✓	
15–18 months	✓						

Source: American Academy of Family Physicians, Recommended Childhood Immunization Schedule – United States, 2005; www.aafp.org/x7666.xml.

Vaccine Abbreviations

DTaP/DT = Diphtheria, tetanus, and pertussis
Hep B = Hepatitis B
IPV = Polio
HiB = Haemophilus influenza type b
MMR = Measles, mumps, and rubella
VZV = Chicken pox
PCV = Pneumonia

The CDC's 2004 vaccination survey of children ages 19 to 35 months reports that Maryland was one of the top-ranked states in vaccinating children against chicken pox. A comparison of childhood immunization rates in Maryland to national rates shows the state exceeds national levels in five out of six vaccines recommended in childhood.

	DTaP	IPV	MMR	Hep B	HiB	VZV
Maryland	97.3%	90.5%	94.8%	93.9%	95.7%	90.2%
Nation	95.9%	91.6%	93.0%	92.4%	93.5%	87.5%

Source: National Immunization Survey, www.cdc.gov/nip/coverage/default.htm#NIS

The Maryland Center for Immunization offers ImmuNet to Maryland immunization providers. ImmuNet is Maryland's immunization registry, a confidential and secure computer database designed to collect and maintain accurate, confidential and current vaccination records. ImmuNet currently contains over 475,000 immunization records. Used in 38 provider offices, it is proving helpful for tracking children in need of vaccinations and assisting public health officials in improving the overall status of immunizations in Maryland.

Measure Definition

This measure shows the percentage of children who turned two years old during 2004, were continuously enrolled in their health plan for the 12 months immediately preceding their second birthday, and have received immunizations, as specified, for the two HEDIS-defined combinations listed below.

Combination 1	Combination 2
4 DTaP/DT	4 DTaP/DT
3 IPV	3 IPV
1 MMR	1 MMR
3 Hep B	3 Hep B
3 HiB	3 HiB
	1 VZV

This report also contains rate results for the specific antigens that comprise each combination vaccine.

Data Collection Methodology

This measure is collected using the hybrid methodology and is eligible for rotation in HEDIS 2005.

Summary of Changes

No significant changes in 2005. In HEDIS 2006, Combination 1 will be retired and Combination 3 will be added to include all antigens, including pneumococcal conjugate vaccine (PCV).

Star Performer

Combination 1 is not reported in the *Consumer Guide* because it no longer constitutes adequate immunization; therefore, it is not eligible for Star Performer designation. Combination 2 is eligible for Star Performer designation.

Notes

Combination 2 is largely compliant with broad guidelines set by the CDC; however, the CDC also recommends four PCV for all children 2–23 months of age, which will be incorporated in HEDIS 2006.

Beginning in 2003, HEDIS guidelines do not count as "compliant" any DTaP/DTP, IPV/ OPV, or HiB vaccinations given to a child younger than six weeks. Administration of the oral polio vaccine does not meet the criteria for this measure.

Several factors complicate calculating this measure and can lead to underreporting. When interpreting results, readers should consider the following:

- Children who receive some—or even most, but not all—of the immunizations specified for the combination are excluded from the numerator of the rate. Vaccine-specific or single antigen rates are almost always higher than the rates for combinations, but they alone do not constitute adequate immunization.
- All plans have difficulties documenting immunizations that children received outside of their network (e.g., at schools, local health departments).
- Disease history may not be documented. Unless a child's medical record shows evidence of having had the disease, underreporting will occur without the necessary documentation of the specific medical event.
- Poor quality of coding for ambulatory data is commonly found in capitated managed care environments and can complicate accurate measurement. Providers often do not include antigen-specific codes for immunizations on encounter forms submitted to plans.
- Many children receive recommended immunizations shortly *after* their second birthday. Although the intent of the measure is satisfied, these children must be excluded (as indicated in the *HEDIS 2005, Volume 2: Technical Specifications*, which guide the calculation of rates for HEDIS measures to ensure comparability of results across plans).

Results

Combination 1 (see Table 5)

- From 2003 to 2005, the Maryland HMO/POS average increased four percentage points to 79%.
- In 2005, rates ranged from 73% to 87%, with two plans receiving above average, three plans average, and two plans below average scores.
- This combination is displayed for the purpose of showing trends over time, but is no longer where plans should focus their attention; it will be retired in HEDIS 2006. Combination 2 is the currently measured standard of performance.

Combination 2 (see Table 6)

- From 2003 to 2005, the Maryland HMO/POS average increased five percentage points to 77%.
- Two plans showed improvements in performance between 2003 and 2005, and one plan's performance declined since 2003.
- In 2005, rates ranged from 71% to 86%, with one plan receiving above average, four plans average, and two plans below average scores.
- One plan received Star Performer designation for this measure.

Antigen-Specific Vaccination Rates (see Table 7)

- This table shows the rates for antigen-specific vaccinations.

Table 5

Combination 1 does not include the chicken pox vaccine (VZV).

Childhood Immunization Status Combination 1, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**75%**	**77%**	**79%**	**4%**			
Aetna	71%	68%	73%	⇔	⊙	○	○
BlueChoice	70%	71%	77%	🡅	○	○	⊙
CIGNA[r]	81%	82%	82%	⇔	●	●	⊙
Coventry[r]	74%	83%	83%	🡅	⊙	●	●
Kaiser Permanente	92%	86%	87%	🡇	●	●	●
M.D. IPA	80%	77%	77%	⇔	●	⊙	⊙
OCI	76%	74%	74%	⇔	⊙	⊙	○

Table 6

Combination 2 includes the chicken pox vaccine (VZV).

Childhood Immunization Status Combination 2, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**72%**	**75%**	**77%**	**5%**			
Aetna	70%	66%	71%	⇔	⊙	○	○
BlueChoice	68%	69%	75%	🡅	○	○	⊙
CIGNA[r]	78%	81%	81%	⇔	●	●	⊙
Coventry[r]	67%	81%	81%	🡅	○	●	⊙
*Kaiser Permanente	91%	86%	86%	🡇	●	●	●
M.D. IPA	78%	74%	75%	⇔	●	⊙	⊙
OCI	72%	72%	72%	⇔	⊙	⊙	○

Legend

Change 2003–2005

- 🡅 Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- 🡇 Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2005 and this plan elected to resubmit 2004 data in 2005.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

Table 7

Childhood Immunization Status, 2005 Results																
Percentage of Children Immunized																
	Combination 1		Combination 2		DTaP		IPV		MMR		HiB		Hep B		VZV	
Maryland HMO/POS Average	**79%**		**77%**		**88%**		**92%**		**94%**		**91%**		**88%**		**93%**	
Aetna	73%	○	71%	○	85%	⊙	90%	⊙	94%	⊙	88%	○	85%	⊙	92%	⊙
BlueChoice	77%	⊙	75%	⊙	85%	⊙	91%	⊙	93%	⊙	96%	●	88%	⊙	92%	⊙
CIGNA	82%	⊙	81%	⊙	89%	⊙	94%	⊙	93%	⊙	91%	⊙	90%	⊙	94%	⊙
Coventry	83%	●	81%	⊙	90%	⊙	95%	●	95%	⊙	93%	⊙	93%	●	92%	⊙
Kaiser Permanente	87%	●	86%	●	91%	⊙	95%	●	95%	⊙	90%	⊙	92%	●	95%	⊙
M.D. IPA	77%	⊙	75%	⊙	88%	⊙	91%	⊙	92%	⊙	90%	⊙	85%	○	92%	⊙
OCI	74%	○	72%	○	85%	⊙	90%	⊙	94%	⊙	89%	⊙	84%	○	91%	⊙

Legend

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Combination 1 *does not* include the chicken pox vaccine (VZV). This combination no longer constitutes adequate immunization.
- Combination 2 does include the chicken pox vaccine (VZV).

ADOLESCENT IMMUNIZATION STATUS

Background

Immunizations are just as important to adolescents as they are to children. Although much of the focus for intervention has been on infants and children, health plans should encourage recommended immunizations according to the official schedule for adolescents.

There are 1.25 million chronically infected Americans with hepatitis B (Hep B), of whom 20-30 percent acquired their infection in childhood. Since 1991, the United States has implemented vaccination strategies recommended by the Advisory Committee on Immunization Practices (ACIP)[1] to eliminate Hep B transmission among children and adolescents, as well as other high risk populations. Hepatitis B vaccine is now considered part of routine childhood vaccinations, as a result, the number of new Hep B infections has declined from an average of 260,000 in the 1980s to about 73,000 in 2003 with the greatest decline among children and adolescents (CDC, 2005).

In 2005, the CDC recommends that adolescents ages 11-12 get the new whooping cough booster vaccine. This comes as a response to the rise in the number of cases of whooping cough in infants who have not been immunized as well as a rise in adolescents and adults. The CDC reports that in the United States nearly 40 percent of whooping cough cases have been in adolescents between the ages 10-19. In 2004, it is estimated that there were 19,000 reported cases of the whooping cough, a 63 percent increase from 2003. The whooping cough booster is contained in the tetanus and diphtheria booster already recommended for children after age 11; and therefore, does not require adolescents to receive an additional shot.

The CDC, the American Academy of Pediatrics (AAP), and other experts recommend that, depending on vaccinations received previously, by the time children are 13 years old they should have received a second dose of measles-mumps-rubella (MMR), four hepatitis B (Hep B) vaccines, a tetanus booster, and a chicken pox (VZV) vaccine. If they have already had the disease, they should not receive the vaccination. A fourth polio vaccine at 4–6 years of age is also recommended.

[1] ACIP consists of 15 experts in fields associated with immunization who have been selected by the Secretary of the U.S. Department of Health and Human Services to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the Centers for Disease Control and Prevention on the most effective means to prevent vaccine-preventable diseases.

Recommended Adolescent Immunizations

Age	DTaP/ DT	IPV	MMR	Hep B	VZV	Td	Hep A
2 years +							✓
4–6 years	✓	✓	✓				
11–12 years				✓	✓		
11–16 years						✓	

* *Source: DHMH, Center for Immunization Recommended Childhood Immunization Schedule—2004 includes two doses of hepatitis A vaccine for Baltimore City residents.*

Vaccine Abbreviations

DTaP/DT = Diphtheria, tetanus, and pertussis
Hep A* = Hepatitis A
Hep B = Hepatitis B
IPV = Polio
Td = Tetanus and diphtheria
MMR = Measles, mumps, and rubella
VZV = Chicken pox

Measure Definition

This measure shows the percentage of adolescents who turned age 13 during 2004, were continuously enrolled for 12 months immediately preceding their 13th birthday, and received the following immunizations as specified for each of the NCQA-recognized combinations. As is the case with Childhood Immunization Status, the distinction between Adolescent Immunization Status Combination 1 and 2 is that Combination 2 includes the vaccine for chicken pox (VZV). This is the combination that experts recommend.

Combination 1	**Combination 2**
2nd dose of MMR	2nd dose of MMR
3 Hep B (or 2-dose regimen)	3 Hep B (or 2-dose regimen)
	1 VZV

This report also contains rate results for the specific antigens that comprise each vaccine grouping.

Data Collection Methodology

This measure is collected using the hybrid methodology and is eligible for rotation in HEDIS 2005.

Summary of Changes

No significant changes to HEDIS 2005. In HEDIS 2006, Combination 1 will be retired.

Star Performer

Combination 1 is not reported in the *Consumer Guide* because it no longer constitutes adequate immunization; therefore, it is not eligible for Star Performer designation. Combination 2 is eligible for Star Performer designation.

Notes

Several factors complicate calculating this measure and can lead to underreporting. When interpreting results, readers should consider the following:

- Adolescents who receive some, but not all, of the immunizations specified for the combination are excluded from the rate. Vaccine- or antigen-specific rates are typically higher than combination rates.
- All plans have difficulties documenting immunizations that adolescents received outside of the network (e.g., at schools, local health departments).
- Disease history may not be documented. Unless a child's medical record shows evidence of having had the disease, underreporting will occur without the necessary documentation of a key event.
- Poor quality in coding of ambulatory data is commonly found in capitated managed care environments and can complicate accurate measurement. Providers often do not include antigen-specific codes for immunizations on encounter forms submitted to plans.

Results

Combination 1 (see Table 8)

- From 2003 to 2005, the Maryland HMO/POS average increased fourteen percentage points to 67%.
- All seven plans showed statistically significant increases in their rates.
- In 2005, rates ranged from 58% to 80%, with two plans receiving above average, two plans average, and three plans below average scores.
- This combination is displayed for the purpose of showing trends over time, but is no longer where plans should focus their attention; it will be retired in HEDIS 2006. Combination 2 is the current standard of performance.

Combination 2 (see Table 9)

- From 2003 to 2005, the Maryland HMO/POS average increased sixteen percentage points to 53%.
- Six of the seven plans showed statistically significant improvements in their rates.
- In 2005, rates ranged from 42% to 71%, with one plan receiving above average, four plans average, and two plans below average scores.
- One plan received Star Performer designation for this measure.

Antigen-Specific Vaccination Rates (see Table 10)

- This table shows the rates for antigen-specific vaccinations.
- Consistent with rates for the Childhood Immunization measure, VZV and hepatitis B vaccination rates were lower than those for MMR.

Table 8

Combination 1 does not include the chicken pox vaccine (VZV)

Adolescent Immunization Status Combination 1, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**53%**	**62%**	**67%**	**14%**			
Aetna	45%	53%	66%	↑	○	○	⊙
BlueChoice	45%	54%	58%	↑	○	○	○
CIGNA	45%	62%	64%	↑	○	⊙	⊙
Coventry[r]	72%	80%	80%	↑	●	●	●
Kaiser Permanente[r]	67%	79%	79%	↑	●	●	●
M.D. IPA	51%	58%	59%	↑	⊙	⊙	○
OCI	42%	51%	59%	↑	○	○	○

Table 9

Combination 2 does include the chicken pox vaccine (VZV)

Adolescent Immunization Status Combination 2, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**37%**	**48%**	**53%**	**16%**			
Aetna	30%	37%	55%	↑	○	○	⊙
BlueChoice	34%	43%	50%	↑	⊙	○	⊙
CIGNA	30%	50%	54%	↑	○	⊙	⊙
Coventry[r]	37%	56%	56%	↑	⊙	●	⊙
*Kaiser Permanente[r]	60%	71%	71%	↑	●	●	●
M.D. IPA	39%	43%	42%	⇔	⊙	○	○
OCI	29%	36%	44%	↑	○	○	○

Legend

Change 2003–2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2005 and this plan elected to resubmit 2004 data in 2005.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

Table 10

Adolescent Immunization Status, 2005 Results										
Percentage of Adolescents Immunized										
	Combination 1		Combination 2		MMR		Hep B		VZV	
Maryland HMO/POS Average	**67%**		**53%**		**80%**		**70%**		**63%**	
Aetna	66%	⊙	55%	⊙	81%	⊙	69%	⊙	65%	⊙
BlueChoice	58%	○	50%	⊙	77%	⊙	61%	○	66%	⊙
CIGNA	64%	⊙	54%	⊙	77%	⊙	67%	⊙	64%	⊙
Coventry	80%	●	56%	⊙	92%	●	82%	●	63%	⊙
Kaiser Permanente	79%	●	71%	●	83%	●	82%	●	77%	●
M.D. IPA	59%	○	42%	○	77%	⊙	63%	○	53%	○
OCI	59%	○	44%	○	73%	○	64%	○	53%	○

Legend

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- Combination 1 does not include the chicken pox vaccine (VZV). This combination no longer constitutes adequate immunization.
- Combination 2 does include the chicken pox vaccine (VZV).

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Background

An estimated 10 percent of all children in the United States who see a medical care provider within a given year will be evaluated for pharyngitis (eMedicine.com, 2004). Pharyngitis, an inflammation in the throat frequently resulting in complaints of sore throat, is caused most often by viruses. However, approximately 15 to 30 percent of cases occur from Group A streptococcus bacterial infection (American Academy of Family Physicians). Streptococcal pharyngitis, or strep throat, requires antibiotic treatment to decrease the period of time a person experiences symptoms and to decrease the risk of rheumatic fever. A diagnostic test used in medical offices to quickly identify strep A infections allows practitioners to appropriately prescribe antibiotics.

Excessive use of antibiotics for pharyngitis is highly prevalent. Treatment of viral pharyngitis with antibiotics causes antibiotic resistance and increased risk of complications arising from the side-effects of antibiotic drugs, ranging from fever, drug allergies, and rashes to irreversible toxicities that cause unnecessary morbidity, prolonged hospital stays, and increased health care and legal costs (Cunha, 2001).

Measure Definition

This measure shows the percentage of children 2 through 18 years of age who were diagnosed with bacterial pharyngitis and prescribed an antibiotic, and received a Group A streptococcus test for the episode.

Data Collection Methodology

This measure is collected using administrative methodology.

Summary of Changes

No significant changes.

Star Performer

This measure is not reported in the *Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Results *(see Table 11)*

- The Maryland HMO/POS average increased from 75% in 2004, when it was first reported, to 78% in 2005.
- In 2005, rates ranged from 72% to 89%, with two plans receiving above average, one plan average, and four plans below average scores.

Table 11

Appropriate Testing for Children with Pharyngitis				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**75%**	**78%**		
Aetna	68%	74%	○	○
BlueChoice	72%	82%	○	●
CIGNA	77%	78%	●	⊙
Coventry	60%	72%	○	○
Kaiser Permanente	96%	89%	●	●
M.D. IPA	77%	75%	⊙	○
OCI	76%	76%	⊙	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Background

Colds are most prevalent among children due to their relative lack of resistance to infection and their high contact with other children. Consequently, children have an estimated 6 to 10 colds a year (National Institute of Allergies and Infectious Diseases, 2004).

While existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them. From 1999–2000, data collected as part of the National Ambulatory Medical Care Survey (NAMCS) revealed that 221 antibiotic prescriptions were issued per 1,000 visits for upper respiratory infections (URI) for children younger than 15 years of age in the United States. Inappropriate antibiotic treatment of URIs increases antibiotic resistance, which decreases the effectiveness of currently available drugs to combat bacterial pathogens, and increases an individual's risk of becoming infected with a drug-resistant pathogen.

Measure Definition

This measure shows the percentage of children 3 months to 18 years of age who were diagnosed with URI and were *not* dispensed an antibiotic on or 3 days after the diagnosis.

Data Collection Methodology

This measure is collected using administrative methodology.

Summary of Changes

No significant changes.

Star Performer

This measure is not reported in the *Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Notes

- This process measure assesses if antibiotics were inappropriately prescribed for children with URI. It is also the first measure in HEDIS evaluating antibiotic prescribing and utilization.
- This measure is reported as an inverted rate [1 minus (numerator/ denominator)]; therefore, a higher score indicates appropriate treatment of children with upper respiratory infection (the number of children who were *not* prescribed an antibiotic).

Results *(see Table 12)*

- The Maryland HMO/POS average increased from 87% in 2004, when this measure was first reported, to 89% in 2005.
- In 2005, rates ranged from 82% to 95%, with three plans receiving above average, one plan average, and three plans below average scores.

Table 12

Appropriate Treatment for Children with Upper Respiratory Infection				
	Comparison of Absolute Rates		*Comparision of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**87%**	**89%**		
Aetna	83%	82%	○	○
BlueChoice	90%	90%	●	●
CIGNA	84%	87%	○	○
Coventry	80%	90%	○	⊙
Kaiser Permanente	84%	85%	○	○
M.D. IPA	95%	95%	●	●
OCI	95%	94%	●	●

Legend

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

CHLAMYDIA SCREENING IN WOMEN

Background

Chlamydia is the most common sexually transmitted disease (STD) in the United States. It is often known as a "silent" disease because about 75 percent of infected women have no symptoms (CDC, 2004); consequently, it is highly underreported. In 2003, 877,478 chlamydia infections were reported to CDC, up from 834,555 cases reported in 2002. However, the CDC estimates that approximately three million Americans are infected with chlamydia each year.

Chlamydia is the most frequently reported STD in Maryland. The Community Health Administration of the Maryland Department of Health and Mental Hygiene reports that from 2002 to 2004 the number of cases of chlamydia in Maryland increased by over 3,000 cases with almost 20,000 cases reported in 2004.

When chlamydia goes undetected and untreated in women it can lead to pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and chronic pelvic pain. A woman with chlamydia is also three to five times more likely to acquire HIV if she is exposed to it. Reported rates for chlamydia are highest among women 15–24 years of age. Of those in the United States population infected with chlamydia, 46 percent of women are 15–19 years of age, while 33 percent of women are 20–34 years of age. By age 30, 50 percent of sexually active women have evidence that they may have been exposed to chlamydia at some point in their lives (CDC, 2004).

Measure Definition

This measure shows the percentage of sexually active women in the age ranges 16–20, 21–25, and 16–25 who were continuously enrolled during 2004 and had at least one test for chlamydia during the measurement year.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes

In 2004, the denominator to identify sexually active women and codes to identify Chlamydia Screening were revised. Additionally, the age range for this measure changed, from women 16–26 to 16–25, which reflects the current clinical guidelines. These changes in specifications are expected to increase rates; therefore, this measure is not trendable for 2003–2005.

Star Performer

The Chlamydia Screening measure (ages 16–25) is included in the *Consumer Guide;* therefore, is eligible for Star Performer designation.

Notes

There are two methods to identify sexually active women for inclusion in the measure: through pharmacy data or through medical claims/encounter data.

Several factors complicate calculating this measure and can influence results. When interpreting results, readers should consider the following:

- As indicated, sexual activity is identified through pharmacy data and claims/encounter data. This method cannot identify all women who were sexually active, only those who received care related to sexual activity, such as prescriptions for contraceptives and pregnancy-related care. The actual number of women at risk is much larger than the number screened. The percentage of women being screened by some plans is only a small fraction of those who meet the criteria for screening. Women meeting the criteria for screening, in turn, make up only a small percent of women at risk.
- Due to privacy concerns, providers may underreport the number of chlamydia tests performed.

Results (see Tables 13-15)

- In 2005, for the combined 16-25 age group, the Maryland HMO/POS average rate for screening was 42%.
- Rates for the combined 16-25 year age group ranged widely from 32% to 78%, with one plan receiving an above average score, and six plans below average scores.
- One plan received Star Performer designation for this measure.

Table 13

Chlamydia Screening Ages 16-20						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**32%**	**38%**	**43%**			
Aetna	18%	26%	39%	○	○	○
BlueChoice	24%	28%	39%	○	○	○
CIGNA	33%	33%	34%	⊙	○	○
Coventry	29%	41%	38%	○	⊙	○
Kaiser Permanente	77%	77%	77%	●	●	●
M.D. IPA	31%	35%	37%	○	○	○
OCI	32%	30%	34%	⊙	○	○

Table 14

Chlamydia Screening Ages 21-25						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**31%**	**37%**	**41%**			
Aetna	16%	25%	36%	○	○	○
BlueChoice	29%	33%	35%	○	○	○
CIGNA	33%	33%	37%	●	○	○
Coventry	22%	35%	38%	○	○	○
Kaiser Permanente	79%	75%	79%	●	●	●
M.D. IPA	22%	31%	34%	○	○	○
OCI	29%	29%	31%	○	○	○

Legend

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 15

Chlamydia Screening Combined Ages 16-25						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**32%**	**38%**	**42%**			
Aetna	17%	25%	38%	○	○	○
BlueChoice	27%	31%	37%	○	○	○
CIGNA	33%	33%	36%	⊙	○	○
Coventry	25%	38%	38%	○	⊙	○
*Kaiser Permanente	78%	76%	78%	●	●	●
M.D. IPA	27%	33%	36%	○	○	○
OCI	30%	30%	32%	○	○	○

Legend

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

CONTROLLING HIGH BLOOD PRESSURE

Background

Heart disease is the leading cause of death for Americans. Detection and treatment of high blood pressure improves cardiovascular health and may prevent fatal or debilitating cardiovascular events. Fifty million or more Americans have high blood pressure that warrants treatment, according to the NHANES survey (Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure [JNC-7], 2003). The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy (JNC-7, 2003). Better control of blood pressure has been shown to significantly reduce the occurrence of these undesirable and costly outcomes. It can occur in children or adults, but is most common in those over the age of 35. The lifetime risk of developing high blood pressure is about 90 percent for men and women ages 55 and 65 according to the American Heart Association (2003).

The prevalence of hypertension varies in the population by (JNC-7, 2003):

- Age: prevalence and increased risk is higher in adults 40 to 89 years of age
- Gender: hypertension is more common among men in early adulthood; however, after the age of 50, hypertension in women increases faster than in men, and after the age of 60 the prevalence of hypertension in women is equal to or exceeds that in men
- Race: blacks are more likely to have hypertension than whites
- Socioeconomic status: people with lower incomes and lower educational levels are more likely to have hypertension than those with higher incomes and education levels

The USPSTF (2003) recommends that clinicians screen adults aged 18 and older for high blood pressure.

Measure Definition

This measure shows the percentage of members age 46 to 85 years who were continuously enrolled in 2004 and had a diagnosis of hypertension and had their blood pressure controlled. A member is considered "in control" if the most recent blood pressure (BP) reading indicates a representative systolic pressure less than or equal to 140 mmHg and a representative diastolic pressure less than or equal to 90 mmHg (i.e., less than or equal to BP of 140/90).

In HEDIS 2007, the specifications for this measure may change to include a decrease in the lower age limit from age 46 to 18 and a change in the blood pressure measurement from less than or equal (≤) 140/90 to less than (<) BP of 140/90.

Data Collection Methodology

This measure is collected using the hybrid methodology.

Summary of Changes

No significant changes to this measure.

Star Performer

This measure was not included in the *2004 Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Results *(see Table 16)*

- From 2003 to 2005, the Maryland HMO/POS average increased five percentage points to 66%.
- Three of the six plans reporting for all three years improved their rates. Trend data was not available for one plan.
- In 2005, rates varied from 53% to 79%, with two plans receiving above average, three plans average, and two plans below average scores.

Table 16

Controlling High Blood Pressure, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**61%**	**65%**	**66%**	**5%**			
Aetna	NR	61%	67%	--	NR	○	⊙
BlueChoice	58%	66%	70%	⇑	⊙	⊙	⊙
CIGNA	76%	76%	79%	⇔	●	●	●
Coventry	57%	57%	65%	⇑	⊙	○	⊙
Kaiser Permanente	54%	79%	73%	⇑	○	●	●
M.D. IPA	60%	60%	55%	⇔	⊙	○	○
OCI[r]	59%	59%	53%	⇔	⊙	○	○

Legend

Change 2003 – 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- NR= Not Reportable. Data did not pass independent audit.

BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Background

According to the National Heart, Lung, and Blood Institute (2004), more than a million heart attacks occur in the United States each year, resulting in 515,000 deaths. Those who have had a heart attack are at higher risk of having another. Approximately 450,000 Americans who will experience an acute myocardial infarction (AMI) will experience a second one. Beta blocker treatment is a medical therapy that has been shown to lower the risk by reducing both blood pressure and how hard the heart has to work.

Beta blockers reduce the risk of death by 25 to 40 percent in patients who had recent heart attacks and reduce sudden cardiac death by up to 50 percent in patients who had a recent heart attack. The earlier treatment is started, the higher the reduction in risk (Journal of the American Heart Association, 2002).

Measure Definition

This measure shows the percentage of members ages 35 years and older, who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction, who were dispensed a prescription for a beta blocker upon discharge.

Data Collection Methodology

This measure is collected using either the administrative or the hybrid methodology. In HEDIS 2005 this measure is eligible for rotation.

Summary of Changes

No significant changes.

Star Performer

This measure is not reported in the *Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Notes

When interpreting these rates, readers should understand plans could exclude any member identified as having a contraindication or previous adverse reaction to beta blocker therapy.

Results *(see Table 17)*

- From 2003-2005, the Maryland HMO/POS average increased one percentage point to 96%.
- In 2005, rates ranged from 88% to 100%, with two plans receiving above average, three plans average, and two plans below average scores.
- Only one of the seven plans showed a statistically significant increase in its rate.

Table 17

Beta-Blocker Treatment After Heart Attack, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**95%**	**96%**	**96%**	**1%**			
Aetna[r]	98%	96%	96%	⇔	●	⊙	⊙
BlueChoice	95%	95%	97%	⇔	⊙	⊙	⊙
CIGNA[r]	96%	97%	97%	⇔	⊙	⊙	⊙
Coventry[r]	90%	100%	100%	⇑	⊙	●	●
Kaiser Permanente[r]	100%	100%	100%	⇔	●	●	●
M.D. IPA	94%	94%	92%	⇔	⊙	⊙	○
OCI	92%	92%	88%	⇔	⊙	○	○

Legend

Change 2003 – 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2005, and this plan elected to re-submit 2004 data in 2005.

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Background

According to the American Heart Association, an estimated 7.8 million American ages 20 years and older have a history of myocardial infarction. In order to reduce mortality during acute or long-term management of myocardial infarctions, the American Heart Association and the American College of Cardiology recommend initiating beta blocker therapy within a few days of the incident and continuing therapy indefinitely. It is estimated that if all heart attack survivors received timely beta-blocker therapy and continued treatment for twenty years it would result in 4,300 fewer chronic heart disease deaths, prevent 3,500 heart attacks, and 45,000 life-years would be gained (Academy for Health Services Research and Health Policy, 2000).

Measure Definition

This measure shows the percentage of members ages 35 years and older, who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction, who received persistent beta blocker treatment for six months after discharge.

Data Collection Method

This measure is collected using administrative methodology.

Summary of Changes

This measure is new for HEDIS 2005.

Star Performer

This measure was reported for the first time in the *Consumer Guide*; therefore, it is not eligible for Star Performer status.

Notes

When interpreting these rates, readers should understand plans could exclude any member identified as having a contraindication or previous adverse reaction to beta blocker therapy.

Results (*see Table 18)*

- The Maryland HMO/POS average was 66% for this first year measure.
- Rates ranged from 44% to 80%, with three plans receiving above average, two plans average, and two plans below average scores.

Table 18

Persistence of Beta-Blocker Treatment After Heart Attack		
	2005	
	Absolute Rates	*Relative Rates*
Maryland HMO/POS Average	**66%**	
Aetna	66%	⊙
BlueChoice	59%	○
CIGNA	64%	⊙
Coventry	44%	○
Kaiser Permanente	75%	●
M.D. IPA	80%	●
OCI	74%	●

Legend

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average.

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

CHOLESTEROL MANAGEMENT AFTER ACUTE CARDIOVASCULAR EVENT

Background

High cholesterol is one of the leading causes of heart attacks among Americans and is one of the principal, modifiable risk factors for heart disease. According to the American Heart Association (AHA), over 100 million American adults have total blood cholesterol levels over 200 mg/dL and 38 million have levels of 240 mg/dL or above. Screening and management of serum cholesterol, especially low-density lipoprotein (LDL-C), is an important and effective way to reduce the suffering and disability caused by coronary heart disease. However, less than half of the people who qualify for cholesterol-lowering therapy are receiving it (AHA, 2004).

Previously, the National Cholesterol Education Program (NCEP) recommended that LDL-C level be less than 130 mg/dL for those at high risk for heart attack. Recently, the American Medical Association released a new report updating the NCEP recommendation. The aim is to reduce the LDL-C level to less than 100 mg/dL. Nearly half of adults over age 20, 48.5 percent of males and 43.3 percent of females, have an LDL-C level of 130 mg/dL or higher.

Two cardiac procedures are commonly used to reduce blockage of the arteries and to increase the flow of blood to the heart: coronary artery bypass graft (CABG) and percutaneous transluminal coronary angioplasty (PTCA). If a plan member has had a heart attack or one of these cardiac procedures, regular monitoring and management of cholesterol levels, particularly LDL-C levels, is essential to reducing the risk of a heart attack.

Measure Definition

This measure shows the percentage of members ages 18-75, who were hospitalized and discharged alive in 2005 after an acute myocardial infarction (AMI), CABG, or PTCA. For these members, the following three rates are calculated:

- The percentage who received a cholesterol (LDL-C) screening on or between 60 and 365 days after discharge (screening);
- The percentage who had a cholesterol (LDL-C) level of <100 mg/dL on or between 60 and 365 days after discharge (control).
- The percentage who had a cholesterol (LDL-C) level of <130 mg/dL on or between 60 and 365 days after discharge (control).

Data Collection Methodology

This measure is collected using either the administrative or the hybrid methodology. In HEDIS 2005 this measure is eligible for rotation.

Summary of Changes

No significant changes.

Star Performer

Cholesterol control LDL-C level <100 mg/dL was a first year measure reported in the *2004 Consumer Guide*; therefore, it is not eligible for Star Performer designation. Cholesterol control LDL-C level <130 mg/dL is eligible for Star Performer designation. The Cholesterol Screening measure was not reported in the *Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Results

Comparison of the screening and control rates across Maryland plans indicates that, while 81% of members who had an acute cardiovascular event received a cholesterol test, only 56% and 72% had cholesterol levels that were known to be "in control" at LDL-C <100 mg/dL and <130 mg/dL, respectively. However, several plans show significant improvement in controlling cholesterol (<130), as indicated by the increased rates for this measure in 2005.

Cholesterol Screening (see Table 19)

- From 2003 to 2005, the Maryland HMO/POS average increased by five percentage points to 81%.
- Two of the seven plans reporting for all three years showed statistically significant increases in their rates.
- In 2005, rates ranged from 76% to 85%, with one plan receiving above average, four plans average, and two plans below average scores.

Cholesterol Control (see Table 20-21)

<u>LDL-C Level <100 mg/dL:</u>

- The Maryland HMO/POS average increased from 52% in 2004 to 56 % in 2005.
- In 2005, rates ranged from 49% to 61%, with two plans receiving above average, four plans average, and one plan below average scores.

<u>LDL-C Level <130 mg/dL:</u>

- From 2003-2005, the Maryland HMO/POS average increased thirteen percentage points to 72%.
- Three of the seven plans reporting for all three years improved their rates.
- In 2005, rates ranged from 67% to 79%, with one plan receiving above average, five plans average, and one plan below average scores.
- No plan received Star Performer designation for this measure.

Table 19

Cholesterol Management, Cholesterol (LDL-C) Screening, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**76%**	**79%**	**81%**	**5%**			
Aetna	79%	73%	76%	⇔	⊙	○	○
BlueChoice	81%	78%	82%	⇔	⊙	⊙	⊙
CIGNA	84%	82%	85%	⇔	●	⊙	⊙
Coventry[r]	68%	81%	81%	↑	○	⊙	⊙
Kaiser Permanente[r m]	79%	78%	78%	⇔	⊙	⊙	○
M.D. IPA	81%	82%	82%	⇔	⊙	⊙	⊙
OCI	77%	77%	85%	↑	⊙	⊙	●

Legend

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2005, and this plan elected to re-submit 2004 data in 2005.
- [m]This plan used the administrative method to calculate this rate.

Table 20

Cholesterol Management, Cholesterol (LDL-C) < 100 mg/dL Control				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**52%**	**56%**		
Aetna	45%	52%	○	⊙
BlueChoice	51%	57%	⊙	⊙
CIGNA	54%	56%	⊙	⊙
Coventry[r]	49%	49%	⊙	○
Kaiser Permanente[r m]	60%	60%	●	●
M.D. IPA	53%	55%	⊙	⊙
OCI	52%	61%	⊙	●

Table 21

Cholesterol Management, Cholesterol (LDL-C) < 130 mg/dL Control, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**59%**	**67%**	**72%**	**13%**			
Aetna	57%	60%	67%	↑	⊙	○	○
BlueChoice	67%	65%	73%	⇔	●	⊙	⊙
CIGNA	73%	74%	76%	⇔	●	●	⊙
Coventry[r]	55%	67%	67%	↑	⊙	⊙	⊙
Kaiser Permanente[r m]	75%	72%	72%	⇔	●	●	⊙
M.D. IPA	68%	69%	69%	⇔	●	⊙	⊙
OCI	65%	65%	79%	↑	●	⊙	●

Legend

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r]This measure was eligible for rotation in 2005, and this plan elected to re-submit 2004 data in 2005.
- [m]This plan used the administrative method to calculate this rate.

COMPREHENSIVE DIABETES CARE

Background

Diabetes is the sixth leading cause of death in the United States. It affects over 18 million people or about 6.3 percent of the population in the United States, according to the Centers for Disease Control and Prevention (2003). Approximately 5 to 10 percent of this population is insulin-dependent (CDC, 2003). The remainder has type II diabetes, which can be controlled through diet or diet and medication. No cure exists for diabetes. Measuring the blood glucose level using a hemoglobin A1c (HbA1c) test is a commonly accepted method of determining whether a patient's diabetes is under control. It is estimated that for every point decease in a patient's HbA1c level, the risk of developing diabetic complications involving the eyes, kidneys, and nervous system is reduced by up to 40 percent (American Diabetes Association, 2004).

Many health complications can arise from diabetes. Cardiovascular disease is closely associated with poor control of diabetes. Studies have shown that women with both coronary artery disease (CAD) and diabetes have a greater chance of dying from these diseases than men with the same two diseases (American Association of Family Physicians). Lipid profiles should be performed regularly. When the patient's LDL-C cholesterol level is controlled cardiovascular complications are reduced up to 20 to 50 percent, and when blood pressure is controlled cardiovascular disease is reduced by 3 to 50 percent (American Diabetes Association, 2004).

According to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), diabetes is the leading cause of end-stage renal disease, accounting for 43 percent of new cases each year. In addition to monitoring for kidney disease, people with diabetes should have their eyes examined regularly for early detection and treatment of degenerative eye diseases such as retinopathy, glaucoma, and cataracts. The CDC (2003) estimates that each year 12,000-24,000 people with diabetes lose their sight.

Measure Definition

This measure shows the percentage of members with diabetes (type I and type II), ages 18-75, who were continuously enrolled during 2004, and had each of the following:

- Blood Glucose (HbA1c) tested; Blood Glucose (HbA1c) controlled (≤9.0%)
- Cholesterol (LDL-C) tested; Cholesterol (LDL-C) controlled (<130 mg/dL and <100 mg/dL)
- Eye exam (retinal)
- Kidney disease (nephropathy) monitored
- Maryland plans also report a Comprehensive Diabetes Care combination rate, which is the percentage of diabetic members who satisfy the numerator requirements for six of the seven Comprehensive Diabetes Care measures described above. The numerator for members whose LDL-C level is less than 100 mg/dL is not considered in the calculation of the combination rate.

Data Collection Methodology

This measure is collected using the hybrid methodology. For this measure only, a plan can elect to report only the administrative rate collected on the sample and opt not to perform medical record review.

Summary of Changes

Due to changes to the Blood Glucose (HbA1c) Control, Eye Exam, and Monitoring for Diabetic Nephropathy measures in 2004, they are not trendable from 2003-2005.

Star Performer

The Blood Glucose (HbA1c) Testing and Cholesterol Testing measures are not in the *Consumer Guide*; therefore, they are not eligible for Star Performer designation. In addition, LDL-C level <100 mg/dL is not eligible for Star Performer designation because it was first reported in 2004. All other measures are eligible for Star Performer designation.

Notes

Methods used to identify members with diabetes can influence final rates. NCQA requires plans to identify people with diabetes using pharmacy data and encounter data. Encounters are "claims" sent to the plan when a member sees a provider. Use of pharmacy data alone tends to exclude people with type II diabetes since medication is not always necessary. Typically, relying on encounter data alone tends to find more false positives, or members who are incorrectly identified as having diabetes. Use of both methods may improve the accuracy of the population used to calculate the rate for each plan.

Results *(see Tables 22-30)*

From 2003 to 2005:

- The Blood Glucose (HbA1c) Testing rate increased one percentage point to 84%.
- The Cholesterol Testing measure increased two percentage points to 91%.
- The Eye Exam rate had an average of 55% and one plan was designated a Star Performer for this measure.

The measure results to this point relate to monitoring or testing services provided to patients. In contrast, the remaining measures are intermediate outcome measures that reflect the impact of managing this chronic disease.

- The Blood Glucose (HbA1c) Control measure reveals that an average of 70% of plan members had HbA1c levels of 9.0% or less. No plan received Star Performer designation for this measure, even though this measure was eligible for Star Performer designation.
- The percentage of members whose cholesterol levels were controlled, as reflected by the Cholesterol Control <130 mg/dL measure, increased 12 percentage points from 2003-2005.
- One plan achieved Star Performer designation for the measure Cholesterol Control <130 mg/dL.

These measures are recognized to be complex and dependent upon proper treatment, ongoing monitoring, and patient cooperation to achieve optimum results.

In 2005, across Maryland plans:

- Rates for the Blood Glucose (HbA1c) and Cholesterol testing measures were significantly higher (85% and 91%, respectively) than rates for the corresponding control measures although the control measures did increase.
- Rates for control measures, Blood Glucose (HbA1c), Cholesterol Control (LDL-C) <130 mg/dL, and Cholesterol Control (LDL-C) <100 mg/dL, were 70%, 69%, and 45% respectively.
- Rates for the Monitoring for Diabetic Nephropathy measure had an average of 53%. One plan received Star Performer designation for this measure.
- Rates for the Maryland specific combination measure were 21% and ranged from 12% to 43%, with one plan receiving above average, two plans average, and four plans below average scores.

In 2005, health plan rates varied widely within each of the Comprehensive Diabetes Care's eight measures as follows:

Measure	Highest Percentage Rate	Lowest Percentage Rate
Blood Glucose Testing	90%	82%
Blood Glucose Control	77%	59%
Cholesterol Testing	93%	88%
Cholesterol Control: <100 mg/dL	55%	38%
Cholesterol Control: <130 mg/dL	77%	63%
Eye Exams	66%	48%
Monitoring Diabetic Nephropathy	70%	40%
Combination Rate	43%	12%

Table 22

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Testing, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**84%**	**83%**	**85%**	**1%**			
Aetna	80%	80%	86%	⇑	○	⊙	⊙
BlueChoice	89%	81%	82%	⇓	●	⊙	⊙
CIGNA	86%	87%	90%	⇔	⊙	●	●
Coventry	82%	80%	84%	⇔	⊙	⊙	⊙
Kaiser Permanente	91%	85%	85%	⇓	●	⊙	⊙
M.D. IPA	85%	86%	85%	⇔	⊙	●	⊙
OCI	85%	82%	83%	⇔	⊙	⊙	⊙

Table 23

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Control, Results						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**66%**	**70%**	**70%**			
Aetna	64%	64%	67%	⊙	○	⊙
BlueChoice	69%	66%	59%	⊙	⊙	○
CIGNA	68%	74%	76%	⊙	●	●
Coventry	65%	67%	66%	⊙	⊙	⊙
Kaiser Permanente	79%	73%	77%	●	⊙	●
M.D. IPA	72%	73%	73%	●	⊙	⊙
OCI	71%	70%	70%	●	⊙	⊙

Legend

Change 2003 – 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 24

Comprehensive Diabetes Care, Cholesterol (LDL-C) Testing, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**89%**	**89%**	**91%**	**2%**			
Aetna	87%	88%	93%	↑	⊙	⊙	●
BlueChoice	91%	88%	91%	⇔	●	⊙	⊙
CIGNA	92%	92%	93%	⇔	●	●	⊙
Coventry	87%	86%	91%	↑	⊙	⊙	⊙
Kaiser Permanente	88%	90%	91%	⇔	⊙	⊙	⊙
M.D. IPA	88%	91%	89%	⇔	⊙	●	⊙
OCI	88%	86%	88%	⇔	⊙	⊙	⊙

Table 25

Comprehensive Diabetes Care, Cholesterol (LDL-C) <100 mg/dL Control				
	Comparison of Actual Rates		*Comparison of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**38%**	**45%**		
Aetna	36%	38%	⊙	○
BlueChoice	37%	44%	⊙	⊙
CIGNA	37%	47%	⊙	⊙
Coventry	38%	40%	⊙	○
Kaiser Permanente	50%	55%	●	●
M.D. IPA	36%	46%	⊙	⊙
OCI	33%	47%	○	⊙

Legend

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 26

Comprehensive Diabetes Care, Cholesterol (LDL-C) <130 mg/dL Control, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**57%**	**64%**	**69%**	**12%**			
Aetna	62%	63%	66%	⇔	●	⊙	⊙
BlueChoice	67%	62%	69%	⇔	●	⊙	⊙
CIGNA	58%	64%	71%	⇑	⊙	⊙	⊙
Coventry	53%	61%	63%	⇑	⊙	⊙	○
*Kaiser Permanente	72%	78%	77%	⇔	●	●	●
M.D. IPA	56%	63%	71%	⇑	⊙	⊙	⊙
OCI	54%	58%	70%	⇑	⊙	○	⊙

Legend

Change 2003 – 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

Table 27

Comprehensive Diabetes Care, Eye Exams						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**51%**	**53%**	**55%**			
Aetna	49%	48%	50%	⊙	○	○
BlueChoice	56%	49%	55%	●	⊙	⊙
CIGNA	46%	48%	51%	⊙	○	⊙
Coventry	56%	52%	55%	●	⊙	⊙
*Kaiser Permanente	78%	73%	66%	●	●	●
M.D. IPA	51%	54%	62%	⊙	⊙	●
OCI	45%	43%	48%	○	○	○

Table 28

Comprehensive Diabetes Care, Monitoring Diabetic Nephropathy						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**51%**	**48%**	**53%**			
Aetna	46%	38%	46%	○	○	○
BlueChoice	42%	42%	52%	○	○	⊙
CIGNA	50%	55%	61%	⊙	●	●
Coventry	54%	49%	55%	⊙	⊙	⊙
*Kaiser Permanente	76%	78%	70%	●	●	●
M.D. IPA	45%	38%	45%	○	○	○
OCI	45%	36%	40%	○	○	○

Legend

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

Table 29

Comprehensive Diabetes Care MHCC- Specific Combination Rating				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**20%**	**21%**		
Aetna	14%	17%	○	○
BlueChoice	13%	19%	○	⊙
CIGNA	21%	24%	⊙	⊙
Coventry	19%	15%	⊙	○
Kaiser Permanente	48%	43%	●	●
M.D. IPA	12%	16%	○	○
OCI	12%	12%	○	○

Legend

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 30

Comprehensive Diabetes Care, 2005 Results																
	Blood Glucose (HbA1c) Testing		Blood Glucose (HbA1c) Control		Cholesterol Testing		Cholesterol Control <100 mg/dL		Cholesterol Control <130 mg/dL		Eye Exams		Monitoring Diabetic Nephropathy		MHCC-specific Combination Measure	
Maryland HMO/POS Average	**85%**		**70%**		**91%**		**45%**		**69%**		**55%**		**53%**		**21%**	
Aetna	86%	⊙	67%	⊙	93%	●	38%	○	66%	⊙	50%	○	46%	○	17%	○
BlueChoice	82%	⊙	59%	○	91%	⊙	44%	⊙	69%	⊙	55%	⊙	52%	⊙	19%	⊙
CIGNA	90%	●	76%	●	93%	⊙	47%	⊙	71%	⊙	51%	⊙	61%	●	24%	⊙
Coventry	84%	⊙	66%	⊙	91%	⊙	40%	○	63%	○	55%	⊙	55%	⊙	15%	○
Kaiser Permanente	85%	⊙	77%	●	91%	⊙	55%	●	77%	●	66%	●	70%	●	43%	●
M.D. IPA	85%	⊙	73%	⊙	89%	⊙	46%	⊙	71%	⊙	62%	●	45%	○	16%	○
OCI	83%	⊙	70%	⊙	88%	⊙	47%	⊙	70%	⊙	48%	○	40%	○	12%	○

Legend

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Background

Asthma is one of the nation's most common and costly conditions. According to the American Lung Association (2004), over 20 million people suffer from asthma including over 6 million children in 2002, making it the sixth leading chronic condition in the United States and the most common chronic disease in children. In 2002, asthma accounted for 1.2 million hospital outpatient visits, 1.9 million emergency department visits, and 12.7 million doctors visits (CDC, 2002). Asthma can be life-threatening; nearly 5,000 people die each year from poor management of the disease. Specific medications, such as corticosteroids, are considered the most effective therapy to control persistent asthma. As reported in the Journal of Allergy and Clinical Immunology (July 2002), only 25 percent of people who should be using anti-inflammatory medicines for long-term control report using them, according to one study. The study concluded that use of inhaled steroids on a regular basis by people with asthma would likely reduce most hospitalizations and deaths. With appropriate therapy and successful management, hospital admissions, emergency department visits, and inpatient length of stay can be reduced.

Measure Definition

This measure shows the percentage of members ages 5-56, who were continuously enrolled during 2003 and 2004, with persistent asthma who were prescribed medications acceptable as primary therapy for long-term control of asthma. People with persistent asthma are defined by HEDIS as having had **any** of the following in 2003 (the year prior to the measurement year):

- at least four asthma medication dispensing events; or
- at least one emergency department visit with asthma as the principal diagnosis; or
- at least one hospitalization with asthma as the principal diagnosis; or
- at least four outpatient visits with asthma as one of the listed diagnoses and a minimum of two asthma medication dispensing events.

The medications identified as acceptable primary therapy are listed on NCQA's Web site: www.ncqa.org.

HEDIS 2005 measure results are reported for four age groups and as a combined rate:

- Ages 5-9 years
- Ages 10-17 years
- Ages 5-17 years (Children)
- Ages 18-56 years (Adults)
- Combined rate (sum of Children and Adults numerators divided by the sum of Children and Adults denominators)

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes

The eligible population, denominator exclusions, and numerator were changed for the age group of 18-56 years and the combined rate. These two rates are not trendable since changes in specification are expected to increase the rates.

Star Performer

This measure is reported in the *Consumer Guide*; therefore, it is eligible for Star Performer designation.

Results *(see Tables 31-33)*

Results are broken down into two age groups: ages 5-17 and ages 18-56.

- For 2005, the Maryland HMO/POS average was higher for adults ages 18-56 at 76%, compared to children ages 5-17 at 73%.
- No plan received Star Performer designation.

Results are also presented for ages 5-9, ages 10-17, and the total population across all age groups (combined rate).

- The Maryland HMO/POS average for the combined age group was 75% in 2005.

Table 31

Use of Appropriate Medications for People With Asthma - Ages 5-17, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**67%**	**69%**	**73%**	**6%**			
Aetna	64%	67%	69%	↑	⊙	⊙	○
BlueChoice	63%	65%	81%	↑	⊙	○	●
CIGNA	65%	66%	73%	↑	⊙	⊙	⊙
Coventry	70%	72%	76%	⇔	⊙	⊙	⊙
Kaiser Permanente	66%	NR[a]	68%	⇔	⊙	NR[a]	○
M.D. IPA	69%	70%	70%	⇔	⊙	⊙	○
OCI	69%	72%	72%	⇔	●	●	⊙

Table 32

Use of Appropriate Medications for People With Asthma - Ages 18-56, Trending						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**71%**	**74%**	**76%**			
Aetna	66%	72%	74%	○	⊙	○
BlueChoice	71%	73%	85%	⊙	⊙	●
CIGNA	65%	70%	74%	○	○	⊙
Coventry	72%	73%	79%	⊙	⊙	⊙
Kaiser Permanente	76%	NR[a]	72%	●	NR[a]	○
M.D. IPA	74%	77%	76%	●	●	⊙
OCI	71%	76%	75%	⊙	●	⊙

Legend:

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- NR[a] = Not Reportable. Underlying data contained errors.

Table 33

Use of Appropriate Medications for People With Asthma, 2005 Results										
	Ages 5-9		Ages 10-17		Ages 5-17		Ages 18-56		Ages Combined	
Maryland HMO/POS Average	**76%**		**70%**		**73%**		**76%**		**75%**	
Aetna	74%	⊙	66%	○	69%	○	74%	○	72%	○
BlueChoice	81%	●	81%	●	81%	●	85%	●	84%	●
CIGNA	78%	⊙	70%	⊙	73%	⊙	74%	⊙	74%	⊙
Coventry	80%	⊙	71%	⊙	76%	⊙	79%	⊙	78%	⊙
Kaiser Permanente	71%	○	66%	○	68%	○	72%	○	70%	○
M.D. IPA	74%	⊙	66%	○	70%	○	76%	⊙	74%	⊙
OCI	75%	⊙	70%	⊙	72%	⊙	75%	⊙	74%	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- NR[a] = Not Reportable. Underlying data contained errors.

FLU SHOTS FOR ADULTS AGES 50-64

Background

An average of 114,000 people in the United States are hospitalized for flu-related complications each year (CDC, 2004). Influenza-related morbidity and mortality among middle-aged adults is particularly significant. Of the 20,000 influenza-associated deaths per year, about 9 percent occur among people ages 50-64 (CDC, 2004).

Influenza vaccination is the primary method for preventing flu and its severe complications. The Advisory Committee on Immunization Practices (ACIP, MMWR, 2005), recommends an annual vaccination for the following risk groups:

- people at increased risk for influenza-related complications (i.e., those ages ≥65 years, children ages 6-23 months, pregnant women, and people of any age with certain chronic medical conditions);
- people ages 50-64 years, as this group has an elevated prevalence of certain chronic medical conditions; and
- people who live with or care for people at high risk (e.g., health-care workers and household contacts who have frequent contact with people at high risk and who can transmit influenza to those people at high risk).

There was a shortage of influenza vaccine in the United States at the beginning of the 2004 flu season. National and state agencies urged only those people at high risk, such as young children, the elderly, health care workers, and those with chronic health conditions, to receive a flu shot. Early media coverage of the shortage and the recommendations from public health officials greatly affected the number of people who received a flu shot, even if they were a part of the high risk group. Flu shot restrictions were lifted in January 2005, but many still did not receive the shot.

Measure Definition

The Flu Shots for Adults Ages 50-64 measure shows the percentage of commercial members as of September 1, 2004 who received an influenza vaccination between September 2004 and the date on which the CAHPS®3.0H Adult Survey was completed.

Data Collection Methodology

This measure is collected through the CAHPS®3.0H survey.

Summary of Changes

No significant changes to this measure.

Star Performer

This measure is not included in the *Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Notes

The measure is collected for two consecutive years to achieve a sufficient denominator. Results are calculated as a moving or rolling average, using data collected during the measurement year and the year preceding the measurement year (i.e., the 2004 and 2005 results are combined to form one rate).

As noted earlier, the shortage of available flu vaccine in the United States may have contributed to the decline in rates. Because of these circumstances, this measure is not trendable for 2003-2005.

Results *(see Table 34-35)*

- In 2005, the Maryland HMO/POS average for members who received a flu shot was 39%, an eight percentage point decrease from 2003.
- Rates ranged from 30% to 48%, with two plans receiving above average, four plans average, and one plan below average scores.
- On average, the majority (45%) of the members who did not get a flu shot chose not to receive the vaccine. Thirty-seven percent reported that they did not ask for the flu shot, while 9% refused to get the flu shot.

Table 34

Flu Shots for Adults Ages 50-64						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**47%**	**48%**	**39%**			
Aetna	44%	51%	48%	⊙	⊙	●
BlueChoice	44%	46%	36%	⊙	⊙	⊙
CIGNA	43%	43%	30%	⊙	⊙	○
Coventry	48%	47%	36%	⊙	⊙	⊙
Kaiser Permanente	53%	51%	45%	●	⊙	●
M.D. IPA	52%	52%	42%	●	⊙	⊙
OCI	42%	46%	38%	⊙	⊙	⊙

Table 35

Reasons for Not Getting a Flu Shot, 2005 Results					
	Didn't ask	**Refused**	**Ineligible**	**Unavailable**	**Other**
Maryland HMO/POS Average	**37%**	**9%**	**8%**	**35%**	**10%**
Aetna	30%	10%	5%	43%	13%
BlueChoice	38%	11%	5%	36%	10%
CIGNA	26%	12%	7%	45%	11%
Coventry	40%	9%	8%	37%	7%
Kaiser Permanente	39%	12%	12%	27%	11%
M.D. IPA	44%	6%	10%	33%	7%
OCI	42%	7%	11%	27%	13%

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

PREVENTION AND EARLY DETECTION OF CANCER

Overview

Death rates from all cancers combined have been decreasing since the early 1990s; however, cancer is still the second leading cause of death in the United States. Nearly half of all men and a little over one third of all women in the United States will develop cancer during their lifetimes. The risk of developing most types of cancer can be reduced by changes in a person's lifestyle, such as quitting smoking and eating a better diet. The sooner a cancer is found and treatment begins, the better the chances of survival (ACS, 2005).

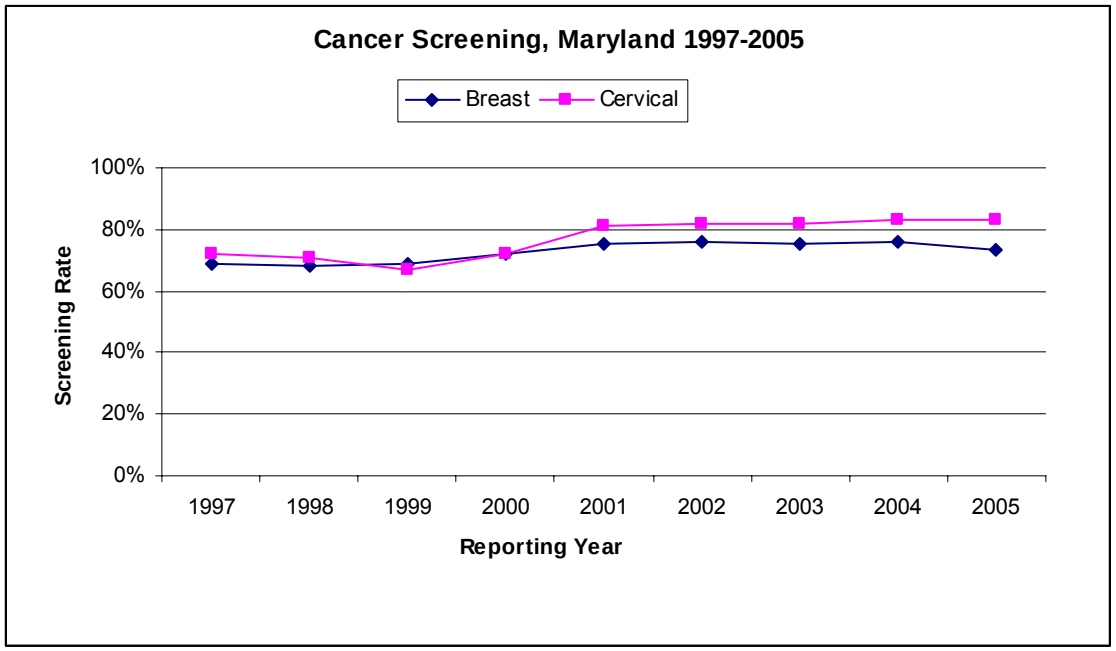
Trends in Cancer

The nation's leading cancer organizations have collaborated to report on the occurrence and trends of cancer in the United States. The *Annual Report to the Nation on the Status of Cancer, 1975-2001* reports that Americans' risk of getting and dying from cancer continues to decline and survival rates for many cancers continue to improve. Findings show overall observed cancer incidence rates dropped 0.5 percent per year from 1991 to 2001, while death rates from all cancers combined dropped 1.1 percent per year from 1993 to 2001. Eleven of the top 15 cancers in men and eight of the top 15 cancers in women show a trend of decreasing death rates although lung cancer deaths rates among women leveled off for the first time between 1995 and 2001, after continuously increasing for many decades. According to the report's authors, the new data reflect progress in prevention, early detection, and treatment; however, not all segments of the United States population have benefited equally from the advances (National Cancer Institute, 2004).

Death rates for Maryland have decreased at a faster rate since 1990 and are now equal to the national average (National Cancer Institute, SEER, 2002).

Cancer Screenings in Maryland

In Maryland, screening rates for breast and cervical cancer have steadily increased for female members enrolled in commercial HMOs. The current reporting year marks the first year breast cancer screening rates have declined; however, the 2005 average rate of screening (73%) reflects a higher proportion of women receiving this care compared to the average rate in 1997 (69%).



The authors of the *Annual Report to the Nation on the Status of Cancer* emphasize that reaching all segments of the population with high-quality prevention, early detection, and treatment services could reduce cancer incidence and mortality even further.

The remainder of this section reports the levels of cancer prevention care provided by Maryland commercial HMOs.

COLORECTAL CANCER SCREENING

Background

Colorectal cancer is the third most common cancer among men and women in the United States. According to the American Cancer Society, an estimated 146,940 new cases of colorectal cancer were diagnosed in the United States in 2004. An average of 23.3 Marylanders per 100,000 died from the disease between 1997 and 2001 (CDC, Cancer Prevention and Control).

Colorectal cancer develops slowly and is often asymptomatic in its early stages. As the cancer progresses, symptoms may begin to appear. More than 90 percent of all diagnosed individuals are over the age of 50, with the risk increasing with age (CDC, Cancer Prevention and Control). According to the National Cancer Institute, less than 25 percent of colorectal cancer cases are associated with evidence of having inherited the disorder; therefore, early detection through screening is vital to detection of this type of cancer.

Measure Definition

This measure shows the percentage of adults 50–80 years of age who had appropriate screening for colorectal cancer.

Data Collection Methodology

This measure is collected using hybrid methodology.

Summary of Changes

No significant change.

Star Performer

This measure was reported for the first time in the 2004 *Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Notes

For this measure, the numerator includes one or more screenings for colorectal cancer. Appropriate screenings must meet one of four criteria, although a person can meet more than one of the criteria:

- fecal occult blood test (FOBT) during the measurement year;
- flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year;
- double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year; or
- colonoscopy during the measurement year or the nine years prior to the measurement year.

Results *(see Table 36)*

- The Maryland HMO/POS average increased from 49% in 2004, when it was first reported, to 53% in 2005.
- In 2005, rates ranged from 49% to 62%, with two plans receiving above average, one plan average, and four plans below average scores.

Table 36

Colorectal Cancer Screening				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**49%**	**53%**		
Aetna	44%	49%	○	○
BlueChoice	52%	62%	⊙	●
CIGNA	52%	53%	⊙	⊙
Coventry	49%	49%	⊙	○
Kaiser Permanente	49%	50%	⊙	○
M.D. IPA	52%	55%	●	●
OCI	47%	50%	○	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

BREAST CANCER SCREENING

Background

Breast cancer ranks as the second leading cause of cancer death in women in the United States. An estimated 40,410 deaths are anticipated in 2005. Mortality rates declined by 2.3 percent per year from 1990 to 2001 in all women due to increased awareness, earlier detection, and improved treatment (ACS, Cancer Facts, 2005). Awareness of the importance of early detection of breast cancer remains high in the United States. For women 40 to 49 years of age, mammography can reduce mortality by 17 percent (AMA, 2003).

Mammograms are the most effective method for detecting breast cancer. A mammogram is an x-ray of the breast that can reveal tumors too small to be felt and can show other changes in the breast that may suggest cancer. A mammogram can detect breast cancer an average of one to three years before a woman may feel a lump (CDC, 2004). When high-quality equipment is used and the x-rays are read by well-trained radiologists 85 percent to 90 percent of cancers are detectable (U.S. Preventive Services Task Force). In 2000, for women 40 years of age and older who had a mammogram within the past two years, the prevalence of mammograms varied by race and ethnicity:

- Asian American (57.0 percent)
- American Indian/Alaskan native (52.4 percent)
- Hispanic/Latina (62.6 percent)
- African American (68.2 percent)
- Non-Hispanic white (72.1 percent)

(ACS, Cancer Prevention & Early Detection Facts & Figures, 2005).

The U.S. Preventive Services Task Force (USPSTF, 2002) recommends screening mammography, with or without clinical breast examination, every one to two years for women 40 years of age and older. The USPSTF found fair evidence that mammography screening every 12 to 33 months significantly reduces mortality from breast cancer. Evidence is strongest for women ages 50 to 69.

Measure Definition

This measure shows the percentage of women ages 50-69 who were continuously enrolled during 2003 and 2004 and who had at least one mammogram during those years.

> *In HEDIS 2007, the specifications for this measure may change to include a decrease in the lower age limit from 50 to 40 years of age and an increase in the upper age limit from 69 to 74 years of age.*

Data Collection Methodology

This measure is collected using either the administrative or hybrid methodology.

Summary of Changes

No significant changes to this measure.

Star Performer

This measure was not reported in the *2004 Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Results *(see Table 37)*

- From 2003 to 2005, the Maryland HMO/POS average decreased by three percentage points to 73%.
- No plans improved their performance from 2003 to 2005, while two plans had decreases in their rates.
- In 2005, rates ranged from 70% to 78%, with one plan receiving an above average score and six plans average scores.

Table 37

Breast Cancer Screening, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**76%**	**76%**	**73%**	**-3%**			
Aetna[m]	67%	71%	70%	⇔	○	○	⊙
BlueChoice	76%	76%	70%	⇔	⊙	⊙	⊙
CIGNA	77%	77%	74%	⇔	⊙	⊙	⊙
Coventry[m]	86%	86%	78%	🡻	●	●	●
Kaiser Permanente[m]	76%	76%	75%	🡻	⊙	⊙	⊙
M.D. IPA[m]	76%	76%	76%	⇔	⊙	⊙	⊙
OCI[m]	68%	70%	70%	⇔	○	○	⊙

Legend:

Change 2003–2005

- 🡹 Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- 🡻 Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [m]This plan used the administrative method to calculate this rate.

CERVICAL CANCER SCREENING

Background

When detected and treated early, cervical cancer can often be cured. The five-year survival rate for cervical cancer is 91 percent if it is detected early. The American Cancer Society (2004) estimates 10,370 new cases of cervical cancer and 3,710 deaths to occur as a result of the disease in 2005.

Cervical cancer can be identified in its early stages by regular screening using a Pap smear test. The Pap smear test detects cell changes, which are precursors to invasive disease. Detecting cervical cancer in its earliest stages is life-saving. The five-year survival rate for localized cancer is 92 percent (USPSTF, 2003). Although the number of cervical cancer deaths has declined over the past several decades, 60 percent to 80 percent of women with cervical cancer have not had a Pap test in the last 5 years (American Cancer Society, 2004). This is especially true of women with low incomes, the elderly, and women of African-American descent who do not access to Pap tests because they are typically uninsured or medically underserved. In women 18 years of age and older in the year 2000, the prevalence of cervical cancer varied by race and ethnicity:

- Asian American (68.2 percent)
- American Indian/Alaskan native (78.4 percent)
- Hispanic/Latina (77.9 percent)
- African American (85.5 percent)
- Non-Hispanic white (83.9 percent)

(ACS, Cancer Prevention & Early Detection Facts & Figures 2005).

A woman who is screened every two years reduces her chances of getting cervical cancer by 86 percent to 91 percent, compared to 61 percent to 74 percent if she has five Pap tests in her lifetime (ACCP fact sheet, 2003). The cervical cancer cure rate approaches 100 percent if the patient is treated when the cancer is in an early stage (ACS Cancer Facts & Figures, 2005).

The American College of Obstetricians and Gynecologists, the American Medical Association, and the American Cancer Society recommend Pap testing every one to three years for all women who have been sexually active or who are over 21 years of age.

Measure Definition

This measure shows the percentage of women 18–64 years of age who were continuously enrolled during 2003–2005 and who received one or more Pap tests during those years.

> *In HEDIS 2007, the specifications for this measure may change to increase the lower age limit, from 18 to 21 years of age.*

Data Collection Methodology

This measure is collected using either the administrative or the hybrid methodology.

Summary of Changes

No significant changes.

Star Performer

This measure is eligible for Star Performer designation.

Results *(see Table 38)*

- From 2003 to 2005, the Maryland HMO/POS average increased by one percentage point to 83%.
- A decline in performance was shown for one plan, while the remaining six plans showed no statistically significant differences in their rates over time.
- In 2005, rates ranged from 81% to 85%, with all seven plans receiving average scores.
- No plan received Star Performer designation for this measure.

Table 38

Cervical Cancer Screening, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**82%**	**83%**	**83%**	**1%**			
Aetna	81%	85%	85%	⇔	⊙	⊙	⊙
BlueChoice	79%	80%	83%	⇔	⊙	○	⊙
CIGNA	81%	82%	83%	⇔	⊙	⊙	⊙
Coventry	81%	81%	82%	⇔	⊙	⊙	⊙
Kaiser Permanente[m]	84%	84%	83%	↓	●	●	⊙
M.D. IPA	84%	83%	83%	⇔	⊙	⊙	⊙
OCI	85%	85%	81%	⇔	⊙	⊙	⊙

Legend

Change 2003–2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- **[m]** This plan used the administrative method to calculate this rate.

MEDICAL ASSISTANCE WITH SMOKING CESSATION

Background

Smoking is the leading preventable cause of death in the United States, causing more than 442,000 deaths each year. An estimated 45.8 million Americans smoke, despite the reported risks and detrimental affect on every organ in the body. The diseases caused by smoking include:

- cancers (such as bladder, esophageal, laryngeal, lung, cervical, kidney, pancreatic, stomach, oral, and throat cancers);
- chronic lung diseases;
- coronary heart and cardiovascular diseases;
- reproductive effects and sudden infant death syndrome;
- abdominal aortic aneurysm;
- acute myeloid leukemia;
- cataract;
- pneumonia; and
- periodontitis (Office of the Surgeon General, 2004).

Quitting smoking reduces the risk of developing these diseases (National Cancer Institute, 2003). Medical assistance with smoking cessation can improve the quit rate. Research shows that physician counseling, without the use of medications, for smoking cessation results in an estimated 1.8 million new quitters. When medications are used along with counseling, an additional 6.7 percent of smokers quit (Wisconsin Medical Journal, 2003).

Measure Definition

There are three components that make up this measure:

- Advising Smokers to Quit shows the percentage of members age 18 and older who are either current smokers or recent quitters and who received advice to quit smoking from their practitioner.
- Discussing Smoking Cessation Medications shows the percentage of members age 18 and older who are either current smokers or recent quitters and whose practitioner recommended or discussed smoking cessation medications.
- Discussing Smoking Cessation Strategies shows the percentage of members age 18 and older who are either current smokers or recent quitters and whose practitioner recommended or discussed smoking cessation methods or strategies.

Data Collection Methodology

This measure is collected through the CAHPS®3.0H survey.

Summary of Changes

No significant changes to this measure.

Star Performer

This measure is not included in the *Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Notes

The measure is collected for two consecutive years to achieve a sufficient denominator. Results are calculated as a moving or rolling average using data collected during the measurement year and the year preceding the measurement year (i.e., the 2004 and 2005 results are combined to form one rate).

Results *(see Table 39-41)*

- In 2005, 73% of members who are current or former smokers received a practitioner's advice to quit compared to 41% who reported that their doctor recommended or discussed cessation medications or strategies.
- These results show that although plan members are being advised to quit smoking less than half are given medications and strategies to aid them in quitting.

Table 39

Advising Smokers to Quit							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2004	2003	2004	2005
Maryland HMO/POS Average	**71%**	**73%**	**73%**	**2%**			
Aetna	70%	73%	69%	⇔	⊙	⊙	⊙
BlueChoice	71%	74%	76%	⇔	⊙	⊙	⊙
CIGNA	65%	69%	74%	⇔	⊙	⊙	⊙
Coventry	73%	70%	73%	⇔	⊙	⊙	⊙
Kaiser Permanente	73%	72%	72%	⇔	⊙	⊙	⊙
M.D. IPA	74%	78%	81%	⇔	⊙	⊙	●
OCI	71%	73%	67%	⇔	⊙	⊙	⊙

Legend:

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 40

Discussing Smoking Cessation Medications		
	2005	
	Absolute Rates	*Relative Rates*
Maryland HMO/POS Average	**41%**	
Aetna	42%	⊙
BlueChoice	42%	⊙
CIGNA	38%	⊙
Coventry	41%	⊙
Kaiser Permanente	33%	○
M.D. IPA	50%	●
OCI	40%	⊙

Table 41

Discussing Smoking Cessation Strategies		
	2005	
	Absolute Rates	*Relative Rates*
Maryland HMO/POS Average	**41%**	
Aetna	39%	⊙
BlueChoice	39%	⊙
CIGNA	45%	⊙
Coventry	34%	○
Kaiser Permanente	37%	⊙
M.D. IPA	54%	●
OCI	39%	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

ACCESS/AVAILABILITY OF CARE

ACCESS/AVAILABILITY OF CARE

Overview

This section presents results for the *Access/Availability of Care* measures that MHCC required Maryland commercial HMOs to report in 2005. The measures approximate the level of access members have to their health care delivery systems.

Measures in Domain

- Adults' Access to Preventive/Ambulatory Health Services
- Children's and Adolescents' Access to Primary Care Practitioners
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Well-Child Visits for Infants and Children (Composite)
- Adolescent Well-Care Visits
- Prenatal and Postpartum Care

Measures Eligible for Rotation

- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescents Well-Care Visits

Plans that chose to rotate any of these measures are identified by the superscript "r" in the results tables.

Adults' Access, Children's and Adolescents' Access

As an estimate of the access members have to primary care services, the Adults' Access and Children's and Adolescents' Access measures report the percentage of the plan's population who saw a practitioner during a specified period of time. It should be noted; however, that the reason a member did not receive care cannot always be linked to access problems. Members may feel that they do not need medical services or may choose not to obtain services. Obtaining an accurate measurement of access to care is a continuing challenge in quality measurement. These HEDIS measures act as proxies for access and can provide valuable information to consumers, purchasers, policy makers, and other stakeholders when considered along with other information.

Quantifying data completeness is particularly difficult since numerous issues can result in a lower-than-expected rate of visits. A low access rate could signify data submission issues with providers, barriers to care for members, or a healthy population that does not need much medical treatment. As rates approach 100 percent, data completeness becomes less likely the issue.

Well-Child and Adolescent Well-Care Visit Measures

The Well-Child and Adolescent Well-Care Visit measures report information on a subset of members who were continuously enrolled in the health plan for a specified period of time and received routine care. MHCC chose to include these measures in this section rather than the HEDIS *Use of Services* domain because of their association to the Adults' Access and Children's Access measures.

Prenatal and Postpartum Care

This measure includes timely initiation of prenatal care and check-ups after delivery.

ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES

Background

The first U.S. Preventive Services Task Force was set up in 1984, because at that time, insurers did not routinely pay for the costs associated with preventive care and primary care physicians did not always give prevention a prominent role in their practices. Government health officials looked to promote preventive services, and through scientific evidence, build a consensus that prevention works (Annals of Internal Medicine, February 2001). The U.S. Preventive Services Task Force (2002) recommends that even healthy adults receive some important preventive services at least once every three years. Preventive health visits require various screenings depending upon the age and medical history of the adult as well as height and weight measurement during each preventive visit. These preventive steps can lead to early detection of illness or disease.

Access to primary care has been shown to correlate with reduced hospital use while preserving quality (Bindham 1995, Bodenheimer 2005). Studies also show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Physicians have a central role to play in fostering these quality-enhancing strategies that can help to slow the growth of health care expenditures (Bodenheimer, 2005).

Measure Definition

This measure shows the percentage of members ages 20-44 and 45-64 years who had at least one ambulatory or preventive care visit during reporting years 2003, 2004, or 2005.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes

No significant changes to this measure.

Star Performer

This measure is not reported in the *Consumer Guide* because rates have remained consistently level; therefore, it is not eligible for Star Performer designation.

Notes

The relatively high number of plans considered above or below average is partially a result of the fact that this measure is calculated on administrative data only. Since samples are not used, the number of people who meet criteria for the measure is relatively large and confidence intervals are small, increasing the likelihood that variations in plan rates are statistically significant.

Results

Ages 20-44 (see Table 42)

- From 2003 to 2005, the Maryland HMO/POS average increased one percentage point to 93%.
- Four of the seven plans increased their rates, one plan did not show any statistically significant change in its rate, while two plans decreased their rates.
- In 2005, rates ranged from 91% to 95%, with three plans receiving above average and four plans below average scores.

Ages 45-64 (see Table 43)

- From 2003 to 2005, the Maryland HMO/POS average showed no change remaining at 94%.
- Four of the seven plans increased their rates, two plans did not show any statistically significant change in their rates, and one plan decreased its rate.
- In 2005, rates ranged from 93% to 96%, with three plans receiving above average scores and four plans below average scores.

Combined Measure: Ages 20-64 (see Table 44)

- From 2003 to 2005, the Maryland HMO/POS average showed no change remaining at 93%.
- Four of the seven plans increased their rates, two plans did not show statistically significant any change in their rates, and one plan decreased its rate.
- In 2005, rates ranged from 92% to 96%, with three plans receiving above average and four plans below average scores.

Table 42

Adults' Access to Preventive/Ambulatory Health Services, Ages 20-44, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**92%**	**92%**	**93%**	**1%**			
Aetna	92%	91%	91%	⇔	○	○	○
BlueChoice	89%	91%	91%	↑	○	○	○
CIGNA	90%	91%	92%	↑	○	○	○
Coventry	94%	95%	95%	↑	●	●	●
Kaiser Permanente	93%	93%	94%	↑	●	●	●
M.D. IPA	93%	93%	93%	↓	●	●	●
OCI	92%	91%	92%	↓	●	○	○

Table 43

Adults' Access to Preventive/Ambulatory Health Services, Ages 45-64, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**94%**	**94%**	**94%**	**0%**			
Aetna	93%	92%	93%	⇔	○	○	○
BlueChoice	93%	93%	94%	↑	○	○	○
CIGNA	92%	93%	94%	↑	○	○	○
Coventry	96%	96%	96%	⇔	●	●	●
Kaiser Permanente	94%	95%	95%	↑	●	●	●
M.D. IPA	95%	95%	95%	↑	●	●	●
OCI	94%	93%	93%	↓	⊙	○	○

Legend:

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 44

Adults' Access to Preventive/Ambulatory Health Services, Combined Ages 20-64, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**93%**	**93%**	**93%**	**0%**			
Aetna	92%	92%	92%	⇔	○	○	○
BlueChoice	91%	92%	93%	↑	○	○	○
CIGNA	91%	92%	93%	↑	○	○	○
Coventry	95%	95%	96%	↑	●	●	●
Kaiser Permanente	94%	94%	95%	↑	●	●	●
M.D. IPA	94%	94%	94%	⇔	●	●	●
OCI	93%	92%	92%	↓	⊙	○	○

Table 45

Adults' Access to Preventive/Ambulatory Health Services, All Measures, 2005 Results						
	20-44 Years		**45-64 Years**		**20-64 Years**	
Maryland HMO/POS Average	**93%**		**94%**		**93%**	
Aetna	91%	○	93%	○	92%	○
BlueChoice	91%	○	94%	○	93%	○
CIGNA	92%	○	94%	○	93%	○
Coventry	95%	●	96%	●	96%	●
Kaiser Permanente	94%	●	95%	●	95%	●
M.D. IPA	93%	●	95%	●	94%	●
OCI	92%	○	93%	○	92%	○

Legend:

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS

Background

Similar to the Adults' Access to Preventive/Ambulatory Health Services measure, this measure shows whether children and adolescents had at least one visit to a primary care practitioner as a means of determining a minimum level of access to care.

Measure Definition

This measure shows the percentage of:

- children ages 12-24 months and ages 25 months-6 years continuously enrolled in 2004 that had at least one visit to a primary care practitioner during 2004.
- children ages 7-11 years and adolescents ages 12-19 years continuously enrolled during 2003 and 2004 who had at least one visit to a primary care practitioner during 2003 or 2004.

All visits to pediatricians, family physicians, and other health plan primary care practitioners, including physician assistants and nurse practitioners are counted for this measure.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes

No significant changes.

Star Performer

This measure is not reported in the *Consumer Guide* because rates have remained consistently level with all plans reporting high rates; therefore, it is not eligible for Star Performer designation.

Results

Ages 12-24 Months (see Table 46)

- From 2003 to 2005, the Maryland HMO/POS average increased one percentage point to 97%.
- Two of the seven plans increased their rates, and five plans did not show any change in their rates.
- In 2005, rates ranged from 96% to 98%, with two plans receiving above average, three plans average, and two plans below average scores.

Ages 25 Months-6 Years (see Table 47)

- From 2003 to 2005, the Maryland HMO/POS average increased one percentage point to 89%.
- Three of the seven plans increased their rates, and four plans did not show any change in their rates.
- In 2005, rates ranged from 87% to 92%, with three plans receiving above average, two plans average, and two plans below average scores.

Ages 7-11 Years (see Table 48)

- From 2003 to 2005, the Maryland HMO/POS average increased one percentage point to 90%.
- Three of the seven plans showed a statistically significant increase in their rates, and four plans did not show any change in performance.
- In 2005, rates ranged from 87% to 93%, with four plans receiving above average and three plans below average scores.

Ages 12-19 Years (see Table 49)

- The Maryland HMO/POS average increased one percentage point to 86% in 2005, with four plans receiving above average and three plans below average scores.

Table 46

Children's Access to Primary Care Practitioners, 12-24 Months, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**96%**	**97%**	**97%**	**1%**			
Aetna	97%	97%	98%	↑	●	⊙	●
BlueChoice	95%	96%	96%	↑	○	○	○
CIGNA	95%	96%	96%	⇔	⊙	○	○
Coventry	98%	97%	98%	⇔	●	⊙	●
Kaiser Permanente	98%	98%	97%	⇔	●	●	⊙
M.D. IPA	97%	96%	97%	⇔	⊙	○	⊙
OCI	98%	98%	98%	⇔	●	●	⊙

Table 47

Children's Access to Primary Care Practitioners, 25 Months-6 Years, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**88%**	**90%**	**89%**	**1%**			
Aetna	87%	89%	90%	↑	⊙	○	●
BlueChoice	87%	90%	90%	↑	○	⊙	⊙
CIGNA	88%	90%	89%	↑	⊙	⊙	⊙
Coventry	92%	92%	92%	⇔	●	●	●
Kaiser Permanente	91%	92%	90%	⇔	●	●	●
M.D. IPA	87%	87%	87%	⇔	⊙	○	○
OCI	87%	88%	87%	⇔	○	○	○

Legend:

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 48

Children's Access to Primary Care Practitioners, 7-11 Years, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**89%**	**90%**	**90%**	**1%**			
Aetna	85%	87%	88%	↑	○	○	○
BlueChoice	89%	90%	90%	↑	⊙	⊙	●
CIGNA	87%	89%	90%	↑	○	⊙	●
Coventry	93%	93%	93%	⇔	●	●	●
Kaiser Permanente	91%	92%	91%	⇔	●	●	●
M.D. IPA	88%	88%	88%	⇔	○	○	○
OCI	86%	87%	87%	⇔	○	○	○

Table 49

Adolescents' Access to Primary Care Practitioners, 12-19 Years				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**85%**	**86%**		
Aetna	82%	82%	○	○
BlueChoice	86%	86%	⊙	●
CIGNA	86%	87%	⊙	●
Coventry	88%	88%	●	●
Kaiser Permanente	90%	89%	●	●
M.D. IPA	84%	83%	○	○
OCI	83%	83%	○	○

Legend:

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

Table 50

Children's and Adolescents' Access to Primary Care Practitioners, All Measures, 2005 Results								
	12-24 Months		25 Months-6 Years		7-11 Years		12-19 Years	
Maryland HMO/POS Average	**97%**		**89%**		**90%**		**86%**	
Aetna	98%	●	90%	●	88%	○	82%	○
BlueChoice	96%	○	90%	⊙	90%	●	86%	●
CIGNA	96%	○	89%	⊙	90%	●	87%	●
Coventry	98%	●	92%	●	93%	●	88%	●
Kaiser Permanente	97%	⊙	90%	●	91%	●	89%	●
M.D. IPA	97%	⊙	87%	○	88%	○	83%	○
OCI	98%	⊙	87%	○	87%	○	83%	○

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

WELL-CHILD AND ADOLESCENT VISIT MEASURES

This section covers the following measures:

- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Well-Child Visits for Infants and Children (Composite)
- Adolescent Well-Care Visits

Background

Developmental milestones occur rapidly the first year of life when infants undergo substantial changes in physical growth and abilities. Developmentally the infant acquires gross motor skills, hand coordination, and begins to interact with others as social and emotional behaviors emerge. The American Academy of Pediatrics (AAP) recommends 6 well-child visits in the first year of life: the first within the first month of life and then at 2, 4, 6, 9, and 12 months.

Well-child visits during the pre-school and early elementary school years are important to assess the extent to which children are reaching expected milestones thereby increasing their chances of achieving their full potential. Through early detection and intervention, vision, speech, and language problems can be addressed. The AAP recommends annual well-child visits for 2 to 6-year olds.

Finally, an annual preventive health care visit that addresses physical, emotional, and social aspects of health and promotes a healthy lifestyle as well as disease prevention is important for adolescents. Adolescence is a time of transition between childhood and adulthood. During this period, dramatic physical and emotional changes take place. Unintentional injuries, homicide, and suicide are the leading causes of adolescent death with over 10,000 deaths (CDC, 2002). Other health-related issues such as sexually transmitted diseases, substance abuse, pregnancy (rate of 84.5 per 1,000 adolescent females in 2000 [CDC, 2004]) and antisocial behavior can cause physical, emotional, and social problems for adolescents. The American Medical Association Guidelines for Adolescent Preventive Services, the federal government's Bright Futures program, and new AAP guidelines all recommend comprehensive annual check-ups for adolescents.

The AAP sponsored the National Survey of Early Childhood Health (2004), which surveyed more than 2,000 parents of infants and toddlers to gain parents' opinions about the quality of well-child visits. Eighty six percent of the surveyed parents believe that well-child visits are very important for their child's health and development. In addition, 88 percent of parents felt that they received adequate time with their provider during their well-child visit to discuss their questions and concerns.

Measure Definition

Well-Child Visits in the First 15 Months of Life

This measure reports the percentage of children, who turned 15 months old during 2004 and received **six or more** well-child visits by the time they reached 15 months of age.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This measure reports the percentage of children ages 3-6 years in 2004 who received **one or more** well-child visits with a primary care physician during the year.

Well-Child Visits for Infants and Children (Composite)

This measure combines rates of well-child visits for infants ages birth to 15 months and well-child visits for children ages 3-6 years to create one composite measure. Criteria remain the same as in the individual measures.

Adolescent Well-Care Visits

This measure reports the percentage of plan members ages 12-21 years, continuously enrolled during 2004, who received **at least one** well-care visit with a primary care practitioner or an OB/GYN practitioner during year 2004.

Data Collection Methodology

This measure is collected using either the administrative or hybrid methodology. In HEDIS 2005 this measure is eligible for rotation.

Summary of Changes

No significant changes.

Star Performer

The Well-Child Visits for Infants and Children (Composite) and Adolescent Well-Care Visits measures are reported in the *Consumer Guide*; therefore, they are eligible for Star Performer designation.

Notes

These measures are similar to the *Effectiveness of Care* measures in that higher rates indicate better performance. That being the case, trending and relative performance information is presented for these measures.

Several factors complicate calculating these measures and can lead to underreporting. When interpreting results, readers should consider the following:

- Poor quality coding of ambulatory data commonly found in capitated managed care environments could complicate accurate measurement. Providers often do not include codes for well-child visits on encounter forms submitted to HMOs, especially when other procedures are performed during the office visit.

- As noted earlier, these measures are extremely susceptible to data completeness issues. Many plans must use the hybrid method to calculate these measures. However, NCQA criteria for identifying a well-child visit in the medical record are more stringent than for using administrative data. Plans must find evidence of a health and developmental history, both physical and mental; a physical exam; and health education/anticipatory guidance. Due to the level of interpretation allowed by the specifications, many plans have not applied the criteria in a consistent manner.

Results

Individually these measures show a trend by age group that as children grow older they receive less preventive care. Although Maryland HMO/POS plans are showing some improvement in the older age group, this trend is evident in the current Maryland HMO/POS average and over time.

Well-Child Visits in the First 15 Months of Life (see Table 51)

- From 2003 to 2005, the Maryland HMO/POS average increased three percentage points to 72%.
- Two of the seven plans showed statistically significant increases in their rates, two plans did not show any change in performance, and three plans decreased their rates.
- In 2005, rates ranged from 60% to 82%, with three plans receiving above average, two plans average, and two plans below average scores.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (see Table 52)

- From 2003 to 2005, the Maryland HMO/POS average increased three percentage points to 70%.
- Two of the seven plans showed statistically significant increases, while four plans did not show any change, and one plan's rate decreased.
- In 2005, rates ranged from 65% to 72%, with one plan receiving above average, five plans average, and one plan below average scores.

Well-Child Visits for Infants and Children (Composite) (see Table 53)

- From 2003 to 2005, the Maryland HMO/POS average increased three percentage points to 71%.
- Three of the seven plans showed statistically significant increases, while performance for three plans did not show any change, and one plan's rate decreased.
- One plan received Star Performer designation for this measure.

Adolescent Well-Care Visits (see Table 54)

- From 2003 to 2005, the Maryland HMO/POS average increased two percentage points to 38%.
- Four of the seven plans showed statistically significant improvements in their rates, while rates for three plans did not show changes.
- No plan received Star Performer designation for this measure.

Table 51

Well-Child Visits in the First Fifteen Months, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**69%**	**70%**	**72%**	**3%**			
Aetna[m]	58%	57%	60%	⇔	○	○	○
BlueChoice[m]	79%	71%	75%	⇔	●	⊙	●
CIGNA[m]	75%	77%	79%	⇑	●	●	●
Coventry[m]	77%	80%	82%	⇑	●	●	●
Kaiser Permanente[r m]	66%	61%	61%	⇓	○	○	○
M.D. IPA[m]	77%	75%	73%	⇓	●	●	⊙
OCI[m]	73%	73%	71%	⇓	●	●	⊙

Table 52

Well-Child Visits in the 3rd, 4th, 5th, 6th Years, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**67%**	**69%**	**70%**	**3%**			
Aetna[m]	64%	69%	71%	⇑	○	⊙	⊙
BlueChoice[m]	73%	69%	71%	⇔	●	⊙	⊙
CIGNA[m]	63%	67%	69%	⇑	○	○	⊙
Coventry[m]	71%	72%	72%	⇔	●	●	●
Kaiser Permanente[r m]	67%	65%	65%	⇓	⊙	○	○
M.D. IPA[r]	74%	72%	72%	⇔	●	⊙	⊙
OCI[r]	67%	72%	72%	⇔	⊙	⊙	⊙

Legend:

Change 2003 - 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r] This measure was eligible for rotation in 2005, and this plan elected to re-submit 2004 data in 2005.
- [m] This plan used the administrative method to calculate this rate.

Table 53

Well-Child Visits for Infants and Children (Composite), Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**68%**	**70%**	**71%**	**3%**			
Aetna[m]	61%	63%	66%	⇑	○	○	○
BlueChoice[m]	76%	70%	73%	⇔	●	⊙	●
CIGNA[m]	69%	72%	74%	⇑	⊙	●	●
*Coventry[m]	74%	76%	77%	⇑	●	●	●
Kaiser Permanente[r m]	66%	63%	63%	⇓	○	○	○
M.D. IPA[r]	76%	73%	73%	⇔	●	●	⊙
OCI[r]	70%	72%	71%	⇔	●	●	⊙

Table 54

Adolescent Well-Care Visits, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**36%**	**37%**	**38%**	**2%**			
Aetna[m]	35%	36%	38%	⇑	○	⊙	⊙
BlueChoice[m]	38%	38%	42%	⇔	⊙	●	●
CIGNA[m]	32%	35%	38%	⇑	○	○	⊙
Coventry[m]	37%	39%	40%	⇑	⊙	●	●
Kaiser Permanente[r m]	34%	36%	36%	⇑	○	⊙	○
M.D. IPA[r]	42%	38%	38%	⇔	●	⊙	⊙
OCI[r]	42%	36%	36%	⇔	●	⊙	⊙

Legend:

Change 2003 - 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- [r] This measure was eligible for rotation in 2005, and this plan elected to re-submit 2004 data in 2005.
- [m] This plan used the administrative method to calculate this rate.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

Table 55

Well-Child and Adolescent Visits, 2005 Results								
	Well-Child Visits in the First 15 Months		Well-Child Visits in the 3rd, 4th, 5th, 6th Years		Well-Child Visits for Infants and Children (Composite)		Adolescent Well-Care Visits	
Maryland HMO/POS Average	**72%**		**70%**		**71%**		**38%**	
Aetna	60%	○	71%	⊙	66%	○	38%	⊙
BlueChoice	75%	●	71%	⊙	73%	●	42%	●
CIGNA	79%	●	69%	⊙	74%	●	38%	⊙
Coventry	82%	●	72%	●	77%	●	40%	●
Kaiser Permanente	61%	○	65%	○	63%	○	36%	○
M.D. IPA	73%	⊙	72%	⊙	73%	⊙	38%	⊙
OCI	71%	⊙	72%	⊙	71%	⊙	36%	⊙

Legend:

Change 2003 - 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

PRENATAL AND POSTPARTUM CARE

Background

Prenatal Care

There are 4 million births in the United States each year. The incidence of low birth weight infants rose from 7.8 percent in 2002 to 7.9 percent in 2003 (CDC, 2003). Comparatively, Maryland had a higher rate, 9.0 percent in 2002, of babies born under the threshold of 5 pounds, 8 ounces. Low birth weight babies are more likely to have health problems such as breathing difficulty. Very low birth weight babies, those who weigh less than 3 pounds, 5 ounces, face a higher risk of serious, life-threatening problems.

Health plans that provide timely, thorough, and effective prenatal care can help reduce a woman's likelihood of having complications during pregnancy and poor health outcomes for the baby, such as low birth weight or infant mortality. Infant mortality decreased from 2003-2005 from a rate of 6.9 deaths per 1,000 to 6.6 deaths per 1,000 live births (National Vital Statistics Reports, 2005). Racial and ethnic disparities persist, with the black, non-Hispanic infant mortality rate consistently higher than that of other racial or ethnic groups (ChildStats.gov, 2005).

Pregnant women should be seen by a qualified medical practitioner, an obstetrician, family practitioner, or nurse midwife, on a regular basis during pregnancy. The earlier that prenatal care is started, the better the chances that a woman will have a healthy pregnancy, delivery, and baby. The first examination and consultation should take place in the first thirteen weeks of pregnancy, the period known as the "first trimester." During the prenatal care visit, the doctor or midwife will test for high blood pressure and diabetes, two conditions that can place both mother and baby at risk for health problems. Testing for diabetes is especially important because otherwise healthy women can develop "gestational diabetes" (i.e., diabetes that has its onset during pregnancy). The expectant mother will also receive advice on diet and weight gain, vitamin supplements, and lifestyle changes (e.g., quitting smoking and limiting alcohol intake), all of which lead to healthier pregnancies and babies.

The percentage of women who received prenatal care within the first 3 months of pregnancy increased between 2002 and 2003, continuing a pattern that began in the early 1990s. Slightly over 84 percent of women received early prenatal care in 2003 (CDC, 2003).

Postpartum Care

New mothers often go through a period of physical, emotional, and social change while caring for a new baby. In recent years, postpartum depression has become a growing concern with new mothers and their well-being. More than half of women surveyed in 2000 reported having low to moderate depression following the birth of their child (CDC, 2004). Postpartum depression can affect marital relationships, mother-infant bonding, and infant behavior.

The American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once soon after giving birth so that the new mother can be evaluated and receive any necessary assistance. The first postpartum visit includes a physical examination and also provides an opportunity for the health care provider to answer parents' questions, to give family planning guidance, and to offer counseling on nutrition.

Measure Definition

This measure includes two rates based on the population of commercially-insured women who delivered a live baby between November 6, 2003 and November 5, 2004 and who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery. For this population, the measure calculates:

Prenatal Care (Timeliness of Prenatal Care)

The percentage of women who received a prenatal care visit in the first trimester or within 42 days of enrollment in the health plan.

Postpartum Care

The percentage of women who had a postpartum visit on or between 21-56 days after delivery.

Data Collection Methodology

This measure is collected using either the administrative or hybrid methodology.

Summary of Changes

No significant changes.

Star Performer

The Prenatal and Postpartum measure was not reported in the *2004 Consumer Guide*; therefore, it is not eligible for Star Performer designation.

Notes

Several factors can complicate calculating Prenatal and Postpartum Care results. When interpreting results readers should consider the following:

- Demographic, socioeconomic, and cultural factors affect the likelihood of seeking early prenatal care. Demographic and economic profiles of members may be very different among health plans.
- Poor quality coding of maternity data commonly found throughout the industry can complicate accurate measurement by creating difficulties in identifying the true number of live births.
- The majority of HMOs, like other types of plans, use global billing practices. HMOs pay providers a fixed rate for all maternity services from prenatal to postpartum care, including delivery. This payment can make identifying the number and dates of service of the prenatal care visits difficult.

Results

Comparison of the Prenatal and Postpartum rates shows that, across these Maryland plans, more women received appropriate prenatal care (92%) than received any postpartum care (83%). On average, 17% of women did not receive a minimum level of post delivery care.

Prenatal Care (see Table 56)

- From 2003 to 2005, the Maryland HMO/POS average increased eight percentage points to 92%.
- Three of the seven plans showed a statistically significant increase in their rates, while performance of four plans did not change.
- In 2005, rates ranged from 87% to 96%, with two plans receiving above average, three plans average, and two plans below average scores.

Postpartum Care (see Table 57)

- From 2003 to 2005, the Maryland HMO/POS average increased six percentage points to 83%.
- One of the seven plans showed a statistically significant increase, while performance of six plans remained unchanged.
- In 2005, rates ranged from 78% to 87%, with two plans receiving above average, four plans average, and one plan below average scores.

Table 56

Prenatal and Postpartum Care, Prenatal Care, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**84%**	**90%**	**92%**	**8%**			
Aetna	89%	89%	94%	⇑	●	⊙	⊙
BlueChoice	94%	94%	95%	⇔	●	●	●
CIGNA	92%	95%	96%	⇑	●	●	●
Coventry	84%	84%	92%	⇑	⊙	○	⊙
Kaiser Permanente	92%	92%	94%	⇔	●	⊙	⊙
M.D. IPA	85%	86%	88%	⇔	⊙	○	○
OCI[r]	88%	88%	87%	⇔	●	⊙	○

Table 57

Prenatal and Postpartum Care, Postpartum Care, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**77%**	**81%**	**83%**	**6%**			
Aetna	80%	81%	82%	⇔	⊙	⊙	⊙
BlueChoice	83%	83%	82%	⇔	●	⊙	⊙
CIGNA	84%	86%	87%	⇔	●	●	●
Coventry	74%	74%	82%	⇑	⊙	○	⊙
Kaiser Permanente	84%	84%	87%	⇔	●	⊙	●
M.D. IPA	81%	80%	80%	⇔	●	⊙	⊙
OCI	79%	76%	78%	⇔	⊙	○	○

Legend:

Change 2003 – 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

SATISFACTION WITH THE EXPERIENCE OF CARE

SATISFACTION WITH THE EXPERIENCE OF CARE

Overview

This section presents selected results from the CAHPS 3.0H survey. Reponses in this section represent the opinions of HMO/POS members who comprised the samples drawn from the seven plans. Kaiser's POS enrollees were not included in either the survey or the audit. Responses for that plan represent HMO enrollees only. For consumers making enrollment decisions, knowledge of current members' opinions of and level of satisfaction with their health plans provides valuable information. Member surveys systematically gather the type of information that gives consumers more depth of experience than anecdotal evidence from family, friends, and colleagues. The results allow prospective members to assess how well current members believe their plans are meeting their needs.

MHCC contracted with The Myers Group to conduct the CAHPS 3.0H survey. As an NCQA-certified survey vendor, The Myers Group administered the survey according to protocols established by NCQA. A random sample of 1,100 members of each health plan was contacted for participation in the mail survey, with phone follow-up for non-respondents. The survey samples consisted of current health plan members, age 18 and older who were enrolled in the health plan throughout 2004. Survey data collection began in February 2005 and ended in April 2005.

Results presented here are based either on a single survey question or a composite of several questions. Composite measures group several questions that rate similar aspects of health care or health plan services and have the same response options (for instance: questions forming a composite measure would all have *Never/sometimes/usually/always* as response choices).

Measures in Domain

- Rating of Health Plan
- Recommending Plan to Friends/Family
- Few Consumer Complaints
- Health Plan Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Rating of Health Care

Survey data are not included in the independent audit of the HEDIS measures. However, the audit process does ensure that the population files sent to the survey vendor are not significantly biased and meet the technical specifications established by NCQA. These files were used by the survey vendor to draw the random survey samples representing the members of each health plan.

Overall CAHPS 3.0H Survey Results

In general, while CAHPS satisfaction rates have shown some improvement they are substantially less than the increases in HEDIS clinical rates over the 2003 to 2005 period. This may be due, in part, to the ability of plans to improve HEDIS rates by increasing data completeness and improving rate calculation processes. By comparison, the survey questions and methodology are less prone to data quality/completeness issues and, therefore, rate changes are unlikely to be a result of such data issues.

Aggregate performance from 2003 to 2005 shows that seven of the eight CAHPS measures experienced increases. The increases ranged from one to seven percentage points with the highest increase in the Recommending Plan to Friends/Family measure.

Table 58 provides a summary of the 2005 rates for all eight CAHPS measures reported here.

Table 58

Satisfaction with the Experience of Care, 2005 Results								
	Rating of Health Plan[a]	Recommending Plan to Friends/Family[b]	Few Consumer Complaints[c]	Health Plan Customer Service[d]	Getting Needed Care[d]	Getting Care Quickly[e]	How Well Doctors Communicate[e]	Rating of Health Care[f]
Maryland HMO/POS Average	**36%**	**38%**	**86%**	**73%**	**77%**	**44%**	**60%**	**45%**
Aetna	○	○	⊙	⊙	○	⊙	⊙	⊙
BlueChoice	⊙	⊙	⊙	○	⊙	⊙	⊙	⊙
CIGNA	○	○	⊙	⊙	⊙	⊙	⊙	⊙
Coventry	⊙	⊙	⊙	⊙	●	●	●	●
Kaiser Permanente	⊙	●	⊙	⊙	⊙	⊙	○	⊙
M.D. IPA	●	●	⊙	●	⊙	⊙	○	⊙
OCI	⊙	⊙	⊙	⊙	⊙	⊙	●	⊙

a. Results based on the percentage of members surveyed who gave their health plan a rating of **9 or 10** on a scale of 0-10 with 10 being the "**best health plan possible**."
b. Results based on the percentage of members surveyed who responded "**definitely yes**" when asked if they would recommend their health plan to friends or family.
c. Results based on the percentage of members surveyed who said they "**did not report**" a complaint or problem with their health plan.
d. Results based on the percentage of members surveyed who responded "**not a problem**" to several related questions.
e. Results based on the percentage of members surveyed who responded "**always**" to several related questions.
f. Results based on the percentage of members surveyed who gave the health care they received a rating of **9 or 10** on a scale of 0-10 with 10 being the "**best health care possible**."

RATING OF HEALTH PLAN

Measure Definition

The survey question asked the following:

"Use any number from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?"

Results (*see Tables 59-60*)

Comparisons of rates are based on the percentage of members surveyed who gave their health plan a rating of **9 or 10** on a scale of 0-10 with 10 being the "**best health plan possible**."

- From 2003 to 2005, the Maryland HMO/POS average increased four percentage points to 36%. This means, on average, a third of respondents rated their plan a 9 or 10.
- In 2005, rates ranged from 30% to 41%, with one plan receiving above average, four plans average, and two plans below average scores.
- One plan received Star Performer designation for this measure.

Table 59

Rating of Health Plan, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**32%**	**34%**	**36%**	**4%**			
Aetna	28%	30%	30%	⇔	⊙	⊙	○
BlueChoice	24%	30%	35%	🡅	○	○	⊙
CIGNA	25%	30%	32%	🡅	○	⊙	○
Coventry	37%	37%	38%	⇔	●	⊙	⊙
Kaiser Permanente	32%	38%	40%	🡅	⊙	⊙	⊙
*M.D. IPA	39%	40%	41%	⇔	●	●	●
OCI	37%	36%	39%	⇔	●	⊙	⊙

Table 60

Rating of Health Plan, 2005 Results			
	Rating 0-6	**Rating 7-8**	**Rating 9-10**
Maryland HMO/POS Average	**23%**	**41%**	**36%**
Aetna	28%	43%	30%
BlueChoice	22%	42%	35%
CIGNA	26%	41%	32%
Coventry	20%	42%	38%
Kaiser Permanente	23%	37%	40%
M.D. IPA	17%	42%	41%
OCI	22%	39%	39%

Legend:

Change 2003 – 2005

- 🡅 Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- 🡇 Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

RECOMMENDING PLAN TO FRIENDS/FAMILY

Measure Definition

The survey question asked the following:

"Would you recommend your health plan to friends or family?"

Results (*see Tables 61-62*)

Comparisons of rates are based on the percentage of members surveyed who responded **"definitely yes"** when asked if they would recommend their health plan to friends or family.

- The Maryland HMO/POS average increased seven percentage points to 38% from 2003 to 2005.
- On average, 38% said they would definitely recommend their plan, while 48% said they probably would recommend their plan.
- Three plans showed significant improvement.
- In 2005, rates ranged from 28% to 47%, with two plans receiving above average, three plans average, and two plans below average scores.
- Two plans received Star Performer designation in this measure.

Table 61

Recommending Plan to Friends/Family, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**31%**	**33%**	**38%**	**7%**			
Aetna	30%	33%	33%	⇔	⊙	⊙	○
BlueChoice	23%	28%	39%	🡅	○	○	⊙
CIGNA	27%	25%	28%	⇔	○	○	○
Coventry	32%	35%	38%	⇔	⊙	⊙	⊙
*Kaiser Permanente	36%	40%	47%	🡅	●	●	●
*M.D. IPA	42%	39%	46%	⇔	●	●	●
OCI	30%	33%	37%	🡅	⊙	⊙	⊙

Table 62

Recommending Plan to Friends/Family, 2005 Results				
	Definitely Yes	**Probably Yes**	**Probably No**	**Definitely No**
Maryland HMO/POS Average	**38%**	**48%**	**9%**	**5%**
Aetna	33%	53%	9%	6%
BlueChoice	39%	49%	8%	4%
CIGNA	28%	52%	13%	7%
Coventry	38%	52%	7%	4%
Kaiser Permanente	47%	37%	10%	5%
M.D. IPA	46%	46%	6%	2%
OCI	37%	49%	8%	6%

Legend:

Change 2003 – 2005

- 🡅 Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- 🡇 Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

FEW CONSUMER COMPLAINTS

Measure Definition

The survey question asked the following:

"In the last 12 months, have you called or written your health plan with a complaint or problem?"

Results (*see Tables 63-64*)

Comparisons of rates are based on the percentage of members surveyed who responded, "**no, did not call or write my health plan with a complaint**." Higher rates mean fewer members complained.

- From 2003 to 2005, the Maryland HMO/POS average increased two percentage points to 86%. On average, 14% of respondents said they had formally complained about their plan during the previous year.
- Two plans' rates showed a statistically significant increase.
- In 2005, rates ranged from 84% to 88%, with all seven plans receiving average scores.
- No plan received Star Performer designation for this measure, even though this measure was eligible.

Table 63

Few Consumer Complaints, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**84%**	**86%**	**86%**	**2%**			
Aetna	86%	86%	88%	⇔	⊙	⊙	⊙
BlueChoice	80%	82%	86%	🡅	⊙	○	⊙
CIGNA	81%	79%	84%	⇔	⊙	○	⊙
Coventry	80%	86%	87%	🡅	○	⊙	⊙
Kaiser Permanente	87%	91%	87%	⇔	●	●	⊙
M.D. IPA	86%	86%	84%	⇔	⊙	⊙	⊙
OCI	86%	89%	88%	⇔	⊙	●	⊙

Table 64

Few Consumer Complaints, 2005 Results		
	Yes, Did Complain	**No, Did Not Complain**
Maryland HMO/POS Average	**14%**	**86%**
Aetna	12%	88%
BlueChoice	14%	86%
CIGNA	16%	84%
Coventry	13%	87%
Kaiser Permanente	13%	87%
M.D. IPA	16%	84%
OCI	12%	88%

Legend:

Change 2003 – 2005

- 🡅 Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- 🡇 Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

HEALTH PLAN CUSTOMER SERVICE

Measure Definition

This measure is a composite of several questions. It consists of the following survey questions:

- *"In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials or Internet?"*

  (Only respondents who looked for information on the Internet or in written materials from the health plan in the last 12 months were asked this question.)

- *"In the last 12 months, how much of a problem, if any, was it to get help you needed when you called your health plan's customer service?"*

  (Only respondents who had to call their health plan's customer service to get information or help in the last 12 months to get care for themselves were asked this question.)

- *"In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?"*

  (Respondents who had no experiences with paperwork for their health plan in the last 12 months were considered not having a problem with paperwork).

Notes

Respondents who had no experience in paperwork automatically scored as "Not a Problem" to the question asked, "In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?"

Results (*see Tables 65-66)*

Comparisons of rates are based on the percentage of members surveyed who responded **"not a problem**" to the preceding questions.

- From 2003 to 2005, the Maryland HMO/POS average increased three percentage points to 73%.
- No plan showed statistically significant increase in rates for this measure.
- In 2005, rates ranged from 69% to 79%, with one plan receiving above average, five plans average, and one plan below average scores.
- One plan received Star Performer designation for this measure.

Table 65

Health Plan Customer Service, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**70%**	**70%**	**73%**	**3%**			
Aetna	67%	69%	73%	⇔	⊙	⊙	⊙
BlueChoice	62%	61%	69%	⇔	○	○	○
CIGNA	65%	62%	70%	⇔	○	○	⊙
Coventry	70%	70%	71%	⇔	⊙	⊙	⊙
Kaiser Permanente	76%	75%	72%	⇔	●	●	⊙
*M.D. IPA	79%	77%	79%	⇔	●	●	●
OCI	72%	73%	77%	⇔	⊙	⊙	⊙

Table 66

Health Plan Customer Service, 2005 Results			
	Big Problem	**Small Problem**	**Not a Problem**
Maryland HMO/POS Average	**8%**	**19%**	**73%**
Aetna	8%	18%	73%
BlueChoice	11%	20%	69%
CIGNA	9%	21%	70%
Coventry	9%	19%	71%
Kaiser Permanente	11%	17%	72%
M.D. IPA	4%	17%	79%
OCI	6%	18%	77%

Legend:

Change 2003 – 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

GETTING NEEDED CARE

Measure Definition

This measure is a composite of several questions. This composite measure consisted of the following survey questions:

- *"Since you joined your health plan, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?"*
  (Only respondents who got a new personal doctor/nurse when they joined the health plan were asked this question.)
- *"In the last 12 months, how much of a problem, if any, was it to see a specialist that you needed to see?"*
  (Only respondents who thought they needed to see a specialist in the last 12 months were asked this question.)
- *"In the last 12 months, how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary?"*
  (Only respondents who thought they needed care, tests, or treatment in the last 12 months for themselves were asked this question.)
- *"In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?*
  (Only respondents who needed approval from their health plan for care, tests, or treatment in the last 12 months for themselves were asked this question.)

Notes

Respondents who did not require approval for care, tests, or treatment were automatically scored as "Not a Problem" to the question, "In the last 12 months, did you need approval from your health plan for any care, test, or treatment?" This composite measure is in the *Consumer Guide*; therefore, it is eligible for Star Performer designation.

Results *(see Tables 67-68)*

Comparisons of rates are based on the percentage of members surveyed who responded "**not a problem**" to the above questions.

- From 2003-2005, the Maryland HMO/POS average increased two percentage points to 77%.
- In 2005, rates ranged from 73% to 86%, with one plan receiving above average, five plans average, and one plan below average scores.
- One plan received Star Performer designation for this measure.

Table 67

Getting Needed Care, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**75%**	**74%**	**77%**	**2%**			
Aetna	73%	70%	73%	⇔	⊙	○	○
BlueChoice	72%	72%	78%	⇔	○	⊙	⊙
CIGNA	68%	67%	75%	⇔	○	○	⊙
*Coventry	81%	82%	86%	⇔	●	●	●
Kaiser Permanente	74%	73%	77%	⇔	⊙	⊙	⊙
M.D. IPA	77%	77%	76%	⇔	⊙	●	⊙
OCI	75%	74%	76%	⇔	⊙	⊙	⊙

Table 68

Getting Needed Care, 2005 Results			
	Big Problem	**Small Problem**	**Not a Problem**
Maryland HMO/POS Average	**7%**	**15%**	**77%**
Aetna	7%	19%	73%
BlueChoice	7%	14%	78%
CIGNA	8%	17%	75%
Coventry	4%	10%	86%
Kaiser Permanente	9%	14%	77%
M.D. IPA	6%	18%	76%
OCI	9%	16%	76%

Legend:

Change 2003 – 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

GETTING CARE QUICKLY

Measure Definition

This measure is a composite of several questions. It consists of the following survey questions:

- *"In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed?"*

  (Only respondents who called a doctor's office during regular office hours to get help or advice for themselves in the last 12 months were asked this question.)

- *"In the last 12 months, when you needed care right away for an illness, injury, or condition, how often did you get care as soon as you wanted?"*
  (Only respondents who thought they needed care right away in the last 12 months were asked this question.)

- *"In the last 12 months, not counting the times you needed health care right away, how often did you get an appointment for health care as soon as you wanted?"*

  (Only respondents who made an appointment for health care they did not need right away in the last 12 months were asked this question.)

- *"In the last 12 months, how often were you taken to the exam room within 15 minutes of your appointment?"*

  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

Notes

This composite measure, Getting Care Quickly, is in the *Consumer Guide*; therefore, it is eligible for Star Performer designation.

Results *(see Tables 69-70)*

Comparisons of rates are based on the percentage of members surveyed who responded **"always"** to the above questions.

- From 2003-2005, the Maryland HMO/POS average increased two percentage points to 44%.
- In 2005, rates ranged from 42% to 49%, with one plan receiving above average and six plans average scores.
- One plan received Star Performer designation for this measure.

Table 69

Getting Care Quickly, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**42%**	**42%**	**44%**	**2%**			
Aetna	45%	42%	42%	⇔	⊙	⊙	⊙
BlueChoice	40%	40%	43%	⇔	⊙	⊙	⊙
CIGNA	38%	37%	43%	⇔	⊙	○	⊙
*Coventry	47%	47%	49%	⇔	●	●	●
Kaiser Permanente	38%	41%	43%	⇔	○	⊙	⊙
M.D. IPA	42%	41%	42%	⇔	⊙	⊙	⊙
OCI	41%	47%	44%	⇔	⊙	●	⊙

Table 70

Getting Care Quickly, 2005 Results			
	Sometimes/ Never	**Usually**	**Always**
Maryland HMO/POS Average	**25%**	**31%**	**44%**
Aetna	28%	30%	42%
BlueChoice	27%	30%	43%
CIGNA	25%	32%	43%
Coventry	19%	32%	49%
Kaiser Permanente	26%	31%	43%
M.D. IPA	26%	32%	42%
OCI	26%	30%	44%

Legend:

Change 2003 – 2005

- ↑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

HOW WELL DOCTORS COMMUNICATE

Measure Definition

This measure is a composite of several questions. Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked the following survey questions:

- *"In the last 12 months, how often did doctors or other health providers listen carefully to you?"*
- *"In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?"*
- *"In the last 12 months, how often did doctors or other health providers show respect for what you had to say?"*
- *"In the last 12 months, how often did doctors or other health providers spend enough time with you?"*

Results *(see Tables 71-72)*

Comparisons of rates are based on the percentage of members surveyed who responded **"always"** to the above questions.

- From 2003 to 2005, the Maryland average increased four percentage points to 60%.
- Two plans reporting for all three years showed a statistically significant improvement in their rates.
- In 2005, rates ranged from 55% to 64%, with two plans receiving above average, three plans average, and two plans below average scores.
- No plan received Star Performer designation for this measure, even though this measure was eligible.

Table 71

How Well Doctors Communicate, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**56%**	**56%**	**60%**	**4%**			
Aetna	62%	58%	57%	⇔	●	⊙	⊙
BlueChoice	55%	56%	60%	⇔	⊙	⊙	⊙
CIGNA	51%	50%	62%	⇑	○	○	⊙
Coventry	61%	59%	64%	⇔	●	⊙	●
Kaiser Permanente	48%	52%	55%	⇑	○	⊙	○
M.D. IPA	57%	56%	55%	⇔	⊙	⊙	○
OCI	58%	57%	64%	⇔	⊙	⊙	●

Table 72

How Well Doctors Communicate, 2005 Results			
	Sometimes/ Never	**Usually**	**Always**
Maryland HMO/POS Average	**10%**	**30%**	**60%**
Aetna	12%	31%	57%
BlueChoice	11%	28%	60%
CIGNA	9%	29%	62%
Coventry	9%	27%	64%
Kaiser Permanente	10%	35%	55%
M.D. IPA	10%	35%	55%
OCI	8%	27%	64%

Legend:

Change 2003 – 2005

- ⇑ Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- ⇓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.

RATING OF HEALTH CARE

Measure Definition

The survey question asked the following:

"Use any number from 0 to 10 where 0 is the worst health care possible, and 10 is the best care possible, what number would you use to rate your health care in the last 12 months?"

Results *(see Tables 73-74)*

Comparisons of rates are based on the percentage of members surveyed who gave their health care a rating of 9 or 10 on a scale of 0-10 with 10 being the "**best health care possible**."

- From 2003 to 2005, the Maryland HMO/POS average did not significantly change.
- One plan reporting for all three years significantly improved its rate.
- In 2005, rates range from 41% to 51%, with one plan receiving above average and six plans average scores.
- One plan received Star Performer designation for this measure.

Table 73

Rating of Health Care, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**45%**	**45%**	**45%**	**0%**			
Aetna	43%	45%	41%	⇔	⊙	⊙	⊙
BlueChoice	44%	46%	48%	⇔	⊙	⊙	⊙
CIGNA	33%	42%	43%	↑	○	⊙	⊙
*Coventry	51%	50%	51%	⇔	●	●	●
Kaiser Permanente	40%	42%	44%	⇔	○	⊙	⊙
M.D. IPA	45%	46%	44%	⇔	⊙	⊙	⊙
OCI	46%	46%	45%	⇔	⊙	⊙	⊙

Table 74

Rating of Health Care, 2005 Results			
	Rating 0-6	**Rating 7-8**	**Rating 9-10**
Maryland HMO/POS Average	**14%**	**40%**	**45%**
Aetna	16%	42%	41%
BlueChoice	14%	38%	48%
CIGNA	16%	41%	43%
Coventry	10%	39%	51%
Kaiser Permanente	16%	40%	44%
M.D. IPA	12%	44%	44%
OCI	16%	39%	45%

Legend:

Change 2003 – 2005

↑ Plan rate increased significantly from 2003 to 2005
⇔ Plan rate *did not* change significantly from 2003 to 2005
↓ Plan rate decreased significantly from 2003 to 2005

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Numbers may not add to 100% due to rounding.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

USE OF SERVICES

USE OF SERVICES

Overview

This section presents results for measures in the HEDIS *Use of Services* domain that MHCC required Maryland HMOs to report in 2005. Descriptive indicators and rates related to facilities utilization include information on inpatient discharges and average lengths of stay, and ambulatory care. Monitoring utilization is essential for any managed care organization and the *Use of Services* rates included in this section can be valuable for analytical purposes.

The *Use of Services* measures are collected as a way of identifying variation in utilization levels. Since no "appropriate" amount of these services has ever been determined, their value is in determining normal distribution of services among various plans. When a plan's rate for a measure is much higher (or lower) than the rates of other plans, it should serve as an indicator that further analysis is warranted to determine what could be contributing to the disparate use rates. Although a standard does not exist for utilization measures, plans may use these results as a means of initially identifying outlier rates. Outlier rates indicate that something different is occurring with the plan, its providers, or its members. Outlier rates could also indicate that a flaw exists within a plan's data collection system. Rates that are three standard deviations from the mean are not included.

The concept behind collecting these data is that once identified, HMOs can target areas for further study or improvement. Results for measures in this domain are affected by many member characteristics that can vary greatly among health plans, including age, gender, current medical condition, socioeconomic status, and race. For frequency of use measures, rates of utilization are often expressed as rates of service used per 1,000 member months or may be converted to rates of service used per year. Unlike *Effectiveness of Care* and *Access/Availability of Care* measures, continuous enrollment criteria do not factor into most of these rate calculations. The number of member months is the sum of the number of months each member is enrolled in the plan each year. For plans with stable memberships, the reported number of member years is close to the number of members enrolled at any point in time during the year. This comparison may not apply to plans with growing or declining enrollment. ***For these measures, rates are not correlated with performance.***

Measures in Domain

- Inpatient Utilization—General Hospital/Acute Care
- Inpatient Utilization—Nonacute Care
- Ambulatory Care
- Discharges and Average Length of Stay—Maternity Care
- Outpatient Drug Utilization
- Frequency of Selected Procedures

Measures related to well-child and adolescent visits and behavioral health in the HEDIS *Use of Services* domain are included in separate sections of this *Comprehensive Report*.

Factors Affecting the Interpretation of Results

Several factors complicate interpretation of the *Use of Services* measures and can lead to misleading results. Readers should consider the following:

- Utilization is significantly influenced by the characteristics of the member population. HEDIS rates are not risk-adjusted so variation in the results between plans may be affected by real differences in member health, race, education, and socioeconomic status. These differences may be most obvious in rates of utilization for various procedures.
- Standards or accepted targets for these rates do not exist. High rates could indicate overutilization while low rates could indicate underutilization; neither higher nor lower rates clearly indicate better performance for some of these measures.
- Many of these measures rely on data for the entire population rather than a sample. Therefore, the results are more likely to be affected by data completeness issues.
- Health plan utilization departments do not always measure utilization using the same method as the HEDIS specifications, so health plans do not have comparable internal rates to determine reasonableness of the results.

As a result of the factors listed above, relative rates (i.e., above/below average scores) are not presented for rates of procedures. Inter-plan comparisons are not appropriate. In addition, given the large number of these measures, only 2005 rates are presented. Rates for previous years can be found in the *Comprehensive Report* for that year.

INPATIENT UTILIZATION—GENERAL HOSPITAL/ACUTE CARE

Measure Definition

This measure reports the rate of utilization of general hospitals for treatment of acute conditions and the average length of stay (ALOS). Rates are reported separately for all patients (**Total**), medical patients (**Medicine**), and surgical patients (**Surgery**). Information on maternity utilization is also presented as a subset measurement, Discharges and Average Length of Stay – Maternity Care, in this section.

Notes

When interpreting this information, it is important to remember that these results are not risk-adjusted for demographic characteristics or severity of the illness. Neither availability nor use of outpatient alternatives is considered.

Results *(see Table 75)*

- The average number of discharges increased per 1,000 members across all categories compared to 2004: Total increased from 58.6 to 60.2, Medical increased from 25.3 to 25.6, and Surgical increased from 19.1 to 20.2.
- In 2005, medical discharges ranged from 21.4 to 27.9 per 1,000 members, and rates for surgical discharges ranged from 14.9 to 26.0 per 1,000 members.
- Average length of stay (ALOS) ranged from 2.7 to 3.7 days for medical patients and 4.1 to 4.7 days for surgical patients.

Table 75

Inpatient Utilization--General Hospital/Acute Care, 2005 Results						
	Discharges/1,000 Members			Average Length of Stay (Days)		
	Total	Medical	Surgical	Total	Medical	Surgical
Maryland HMO/POS Average	**60.2**	**25.6**	**20.2**	**3.5**	**3.2**	**4.4**
Aetna	61.0	27.1	18.7	3.7	3.6	4.3
BlueChoice	61.0	21.4	23.0	3.3	2.9	4.1
CIGNA	59.1	26.1	15.7	3.4	3.2	4.2
Coventry	65.8	27.4	26.0▲	3.6	3.3	4.5
Kaiser Permanente	49.6	22.2	14.9	3.8	3.7	4.7
M.D. IPA	61.2	27.2	21.8	3.4	2.8▼	4.5
OCI	64.1	27.9	21.5	3.3	2.7▼	4.5

"Total" discharges and average lengths of stay include maternity care.

Legend:
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

INPATIENT UTILIZATION—NONACUTE CARE

Measure Definition

This measure reports the rate of utilization and average length of stay for inpatient non-acute care. Inpatient non-acute care includes inpatient care received in the following facilities: hospice, nursing home, rehabilitation, skilled nursing facilities, transitional, and respite care. Mental health and chemical dependency facilities are excluded. Rates are per 1,000 members.

Notes

When interpreting this information, it is important to remember that results are not risk-adjusted for demographic characteristics and use of outpatient alternatives. Data completeness can be a significant issue for many plans when generating this measure, often leading to underreporting.

Results *(see Table 76)*

- In 2005 Maryland plans, on average, reported 2.0 discharges per 1,000 members, with rates ranging from 1.3 to 4.8 discharges per 1,000 members.
- Average length of stay increased from the 2004 reported rate of 12.5 days per 1,000 members to 13.7 days in 2005. ALOS ranged from 10.5 to 15.3 days.

Table 76

Inpatient Utilization--Non-Acute Care, 2005 Results		
	Discharges/1,000 Members	**ALOS (Days)**
Maryland HMO/POS Average	**2.0**	**13.7**
Aetna	1.6	13.1
BlueChoice	1.3	15.1
CIGNA	1.9	12.7
Coventry	1.4	14.6
Kaiser Permanente	4.8▲	10.5
M.D. IPA	1.6	15.3
OCI	1.7	14.1

Legend:
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

AMBULATORY CARE

Measure Definition

This measure reports member use of ambulatory services including outpatient visits, emergency department (ED) visits, and ambulatory surgeries/procedures. Rates are per 1,000 members.

Notes

An outpatient visit is defined as a face-to-face encounter between the practitioner and patient for routine care. It provides a reasonable proxy for professional ambulatory encounters.

ED visits may sometimes be used as a substitute for ambulatory clinic encounters. Although patient behavior is a factor in the decision to use an ED rather than a clinic or physician's office, the decision also may result from insufficient access to primary care. A health plan that provides adequate preventive services and effectively manages ambulatory treatment of patients by offering alternative treatment benefits, such as urgent care coverage, should be able to keep the number of ED visits relatively low. A comparison of plans' ED, outpatient, and urgent care visits per 1,000 members shows that one plan has succeeded in keeping its ED visits low, while maintaining the highest rates of outpatient and urgent care services.

Ambulatory surgeries include procedures performed at a hospital outpatient facility or at a freestanding surgery center; office-based surgeries/procedures are excluded from this measure.

The increasing use of outpatient surgery as an alternative to inpatient surgical procedures can create data interpretation issues. For hospital organizations with semi-attached ambulatory surgery centers, the distinction between places of service may be confused during data processing.

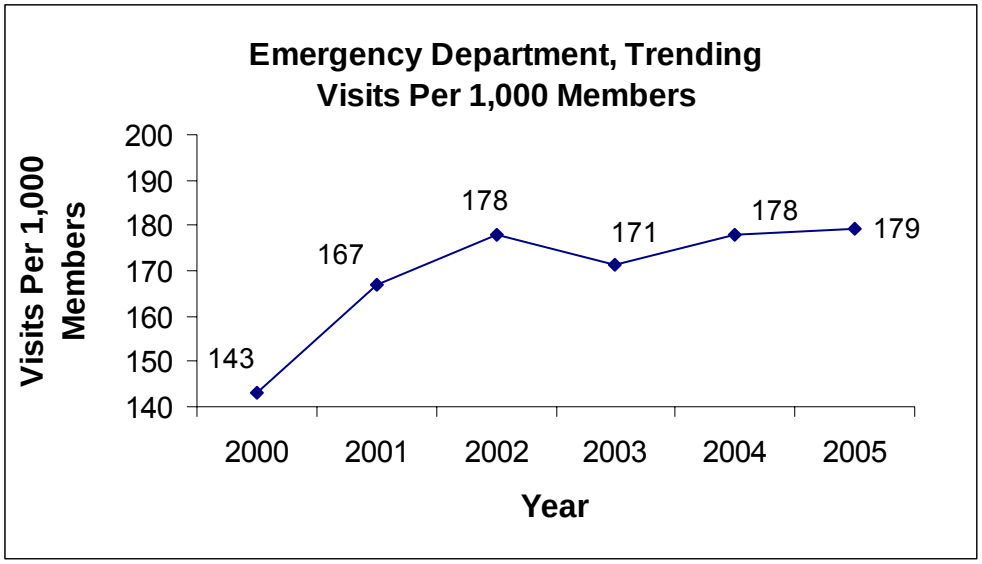
Results *(see Tables 77-78)*

- The Maryland HMO/POS average number of outpatient visits was 3,749, ranging from 3,356 visits to 4,509 visits per 1,000 members.
- The Maryland HMO/POS average number of ED visits was 179 per 1,000 members, ranging from 108 visits to 233 visits per 1,000 members. Compared to the 2004 average rate of 178 visits per 1,000 members, ED visits for this reporting period increased 1 visit per 1,000 members.
- Maryland HMO/POS average rates for ambulatory surgeries/procedures increased from the 2004 rate of 103 to 106 in 2005. Rates ranged from 65 procedures to 164 procedures per 1,000 members.

Table 77

Ambulatory Care, 2005 Results			
	Visits/1,000 Members		
	Outpatient Visits	ED Visits	Ambulatory Surgery/Procedure
Maryland HMO/POS Average	**3,749**	**179**	**106**
Aetna	3,413	177	95
BlueChoice	3,575	233▲	66▼
CIGNA	3,483	199	99
Coventry	4,220	183	164▲
Kaiser Permanente	4,509▲	108▼	65▼
M.D. IPA	3,687	173	132
OCI	3,356	183	125

Table 78



Legend:
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

DISCHARGES AND AVERAGE LENGTH OF STAY—MATERNITY CARE

Measure Definition

This measure reports maternity-related care based upon the **rate of live births** during 2004 and includes the hospital average length of stay related to those births. Delivery information is broken down into vaginal and cesarean section (C-section) categories. Rates are per 1,000 female members age 10 years and older.

Notes

The implementation of Newborns' and Mothers' Health Protection Act of 1996, mandates a minimum length of obstetric stays: two days for vaginal deliveries and four days for C-sections. However, a mother may request a shorter length of stay if she decides in consultation with her provider that less time is needed for recovery. In cases where the mother has a shorter hospital stay than provided for under law, coverage shall be given for one home visit to occur within 24 hours after hospital discharge. Also, this mandate does not establish a follow-up care schedule that could best detect common problems to newborns three to four days after birth.

Plans can provide high-quality care without having longer hospital stays. Safe, but earlier discharges with pediatric and maternal follow-up through home care nursing visits give new mothers an option in their post-delivery care. Plans with long lengths of stay are not necessarily offering more appropriate medical care; they may be responding to legislative mandates or to an individual preference.

The factor that most complicates maternity-related HEDIS measures is the identification of live births. Poor quality coding of maternity data is an industry-wide problem and is the chief culprit complicating accurate measurement for identifying the true number of live births.

Results *(see Table 79)*

- Total maternity discharge rates range from 22.4 per 1,000 female members to 35.8 per 1,000 female members.
- The average length of stay for C-section births is longer, as expected, than for vaginal births (3.9 days compared to 2.2 days).
- The *total* average length of stay varies across plans from 2.5 to 3.1 days.

Table 79

Discharges and Average Length of Stay - Maternity Care, 2005 Results						
	Discharges/1,000 Female Members			Average Length of Stay (Days)		
	Total	Vaginal	C-Section	Total	Vaginal	C-Section
Maryland HMO/POS Average	**27.9**	**18.8**	**9.1**	**2.8**	**2.2**	**3.9**
Aetna	30.8	19.8	11.1	3.1▲	2.4	4.5
BlueChoice	31.0	21.3	9.7	2.8	2.3	3.9
CIGNA	35.8	24.2	11.6	2.9	2.3	4.1
Coventry	23.8	16.5	7.4	2.5	2.1	3.4
Kaiser Permanente	22.4	14.8	7.5	2.8	2.3	3.8
M.D. IPA	22.9	15.5	7.4	2.8	2.3	4.0
OCI	28.6	19.3	9.3	2.7	2.2	3.8

Legend:
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

OUTPATIENT DRUG UTILIZATION

Measure Definition

This measure reports the number of prescriptions dispensed per member, per year and the average cost of prescriptions to the plan per member, per month. Only members whose benefits include prescription drug coverage through their HMOs are included. This measure excludes drugs that members are given in the hospital and only includes prescriptions covered by the member's health plan. Because many employers "carve out" drug benefits from their contracts with health plans, these data do not reflect a true picture of drug use by all plan members.

Notes

Descriptive information about pharmacy services and drug formularies is included in the *Consumer Guide*. Plans accredited by NCQA have met the standards for pharmaceutical management, which includes formulary development. Information about NCQA's pharmacy management standards is included in the External Accreditation section of the *Comprehensive Report*.

Results *(see Table 80)*

- The average commercial HMO member in Maryland received 10.2 prescriptions during the year, costing $41.24 per month. As reported in 2004, the rate was 10.0 prescriptions per member per year. The current reported rate reflects an average increase of 0.2 prescriptions. Additionally, the monthly cost has increased $0.17 per member.
- The number of prescriptions per year ranged widely from 8.7 to 11.6 per member.
- Similarly, the cost per member per month ranged widely from $27.04 to $48.49.

Table 80

Outpatient Drug Utilization, 2005 Results		
	Prescriptions/ Member/Year	**Cost of Prescriptions/ Member/Month**
Maryland HMO/POS Average	**10.2**	**$41.24**
Aetna	9.6	$44.54
BlueChoice	10.1	$39.85
CIGNA	8.7	$41.17
Coventry	9.8	$41.29
Kaiser Permanente	11.6	$27.04▼
M.D. IPA	11.2	$48.49
OCI	10.8	$46.31

Legend:
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

FREQUENCY OF SELECTED PROCEDURES

Background

This measure reports utilization rates for several, mostly surgical, procedures that are performed frequently and contribute substantially to health care costs. Considerable variation exists in how often these procedures are performed. Rates for these measures are likely to be influenced strongly by the way a health plan manages care as well as by the demographic characteristics of the plan's members. Data for this measure, and all subsequent measures in the *Use of Services* section, were collected administratively.

Measure Definition

Utilization rates for the following procedures are included as part of the Frequency of Selected Procedures measure:

Myringotomy—incision of the eardrum to allow the insertion of ventilating tubes; a treatment for chronic ear infections.

Tonsillectomy/Tonsillectomy and Adenoidectomy—surgical removal of the tonsils or tonsils and adenoids.

Non-Obstetric Dilation and Curettage—dilation and surgical cleansing of the surface of the uterus.

Hysterectomy—surgical removal of the uterus.

Cholecystectomy, open—the surgical removal of the gallbladder through an abdominal incision.

Cholecystectomy, closed (laparoscopic)—the surgical removal of the gallbladder with a laparoscope.

Angioplasty—repairing or replacing damaged blood vessels using lasers or tiny inflatable balloons at the end of a catheter that is inserted into the vessels.

Cardiac Catheterization—a procedure used to diagnose the severity and extent of coronary artery disease.

Coronary Artery Bypass Graft—a surgical procedure used to treat coronary heart disease by grafting a portion of a vein from the patient to replace the portion of the coronary artery that is damaged or blocked.

Laminectomy/Diskectomy—surgery for a herniated disk in the spinal column.

Prostatectomy—surgical removal of the prostate gland.

Results *(see Tables 81-85)*

Results for these procedures are presented in the tables on the following pages. To create a comparative base, results appear as rates/1,000 (i.e., the number of times a procedure was performed per 1,000 plan members). This makes it possible to compare very large and very small plans to each other. In most cases, rates are displayed by age and gender because these two factors have much to do with health status and the types of health problems for which people seek care.

Rates for selected procedures included in the *Comprehensive Report* facilitate comparison and analysis by plans, providers, and other organizations. As noted in the Overview section at the beginning of this chapter, utilization rates are significantly influenced by the characteristics of the plan's member population and are vulnerable to data completeness issues. The rates are not risk-adjusted, so variation in the results between plans may not be attributed to differences in performance. Further, there is no accepted standard or target for utilization measures. Therefore, relative rates are not calculated and inter-plan comparisons are not made here. Only 2005 rates are presented. Rates for previous years can be found in the *Comprehensive Report* for the year in question.

It would be prudent for consumers to compare their plan's rate for a procedure they are considering. In some instances, a large number of procedures is a good sign (possibly indicating expertise that often comes from performing a higher volume of the same procedures). In other cases, very high numbers might be a flag indicating that more procedures than necessary are occurring.

Table 81

Frequency of Selected Procedures, 2005 Results				
	Procedures/1,000 Members			
	MYR 0-4 years M&F	MYR 5-19 years M&F	TA 0-9 years M&F	TA 10-19 years M&F
Maryland HMO/POS Average	**38.8**	**3.7**	**7.7**	**3.4**
Aetna	43.2	3.8	7.4	3.2
BlueChoice	23.7	2.4	8.1	3.7
CIGNA	38.2	3.2	7.1	3.8
Coventry	59.7	6.1	10.0	4.1
Kaiser Permanente	17.7▼	2.1	5.7	2.0
M.D. IPA	44.2	3.9	7.4	2.8
OCI	45.2	4.5	8.4	3.9

Notes: MYR=Myringotomy
TA=Tonsillectomy and/or Tonsillectomy and Adenoidectomy
M&F=Male and Female

Table 82

Frequency of Selected Procedures, 2005 Results						
	Procedures/1,000 Members					
	D&C 15-44 yrs Female	D&C 45-64 yrs Female	HYS-ab 15-44 yrs Female	HYS-ab 45-64 yrs Female	HYS-vag 15-44 yrs Female	HYS-vag 45-64 yrs Female
Maryland HMO/POS Average	**4.8**	**6.3**	**3.6**	**5.9**	**1.7**	**2.1**
Aetna	4.8	5.7	3.8	6.0	1.7	2.3
BlueChoice	6.7	8.9	3.2	6.2	1.6	2.1
CIGNA	2.5	2.1	3.1	5.5	1.6	1.9
Coventry	6.9▲	10.9▲	4.7	6.5	2.0	1.9
Kaiser Permanente	0.6▼	1.5	2.8	5.1	0.6▼	1.1▼
M.D. IPA	5.9	7.6	3.9	6.5	2.3	2.4
OCI	6.3	7.5	3.6	5.3	2.3	2.9

Notes: D&C=Dilation & Curettage
HYS-ab=Hysterectomy-abdominal
HYS-vag=Hysterectomy-vaginal

Legend:
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

Table 83

Frequency of Selected Procedures, 2005 Results						
	Procedures/1,000 Members					
	Chol-o 30-64 yrs Male	Chol-o 15-44 yrs Female	Chol-o 45-64 yrs Female	Chol-c 30-64 yrs Male	Chol-c 15-44 yrs Female	Chol-c 45-64 yrs Female
Maryland HMO/POS Average	**0.3**	**0.2**	**0.6**	**1.8**	**4.3**	**5.2**
Aetna	0.3	0.3	0.9▲	1.6	3.8	4.9
BlueChoice	0.3	0.3	0.6	1.9	4.7	5.6
CIGNA	0.2	0.1	0.7	1.8	4.1	5.1
Coventry	0.3	0.2	0.3	2.0	5.6	6.7
Kaiser Permanente	0.4	0.3	0.8	1.1▼	2.3▼	3.1▼
M.D. IPA	0.4	0.2	0.6	2.1	4.4	5.3
OCI	0.4	0.3	0.5	2.2	5.3	5.9

Notes: Chol-o=Cholecystectomy, open
Chol-c=Cholecystectomy, closed (laparoscopic)

Table 84

Frequency of Selected Procedures, 2005 Results			
	Procedures/1,000 Members		
	LD 20-64 yrs Male	LD 20-64 yrs Female	Pros 45-64 yrs Male
Maryland HMO/POS Average	**3.2**	**2.7**	**2.5**
Aetna	2.8	2.4	2.1
BlueChoice	3.4	2.9	2.6
CIGNA	3.1	2.3	2.9
Coventry	3.8	2.7	2.8
Kaiser Permanente	2.2	1.9	1.9
M.D. IPA	3.6	3.0	2.8
OCI	3.6	3.4	2.2

Notes: LD=Laminectomy/Diskectomy
Pros=Prostatectomy

Legend:
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

Table 85

Frequency of Selected Procedures, 2005 Results						
	Procedures/1,000 Members					
	Ang 45-64 yrs Male	Ang 45-64 yrs Female	CC 45-64 yrs Male	CC 45-64 yrs Female	CABG 45-64 yrs Male	CABG 45-64 yrs Female
Maryland HMO/POS Average	**8.0**	**2.4**	**10.8**	**7.7**	**2.7**	**0.8**
Aetna	7.3	2.5	11.9	8.5	2.2	0.6
BlueChoice	8.8	2.6	10.4	7.4	2.5	0.6
CIGNA	7.2	2.0	11.2	7.6	2.0	1.1
Coventry	10.0	3.0	12.2	10.1	4.0	1.1
Kaiser Permanente	5.5▼	1.7	6.3▼	4.0▼	3.2	0.7
M.D. IPA	8.4	2.1	11.8	8.4	2.2	0.7
OCI	9.0	3.1	12.0	7.9	3.0	0.7

Notes: Ang=Angioplasty
CC=Cardiac Catheterization
CABG=Coronary Artery Bypass Graft

Legend:
▲ Plan rate is higher than 90% of other plans, nationally.
▼ Plan rate is lower than 90% of other plans, nationally.

BEHAVIORAL HEALTH CARE

BEHAVIORAL HEALTH CARE

Overview

This section contains results for performance indicators related to behavioral health care from the HEDIS *Effectiveness of Care* and *Use of Services* domains of care. MHCC required Maryland commercial HMOs to report these measures, which were recommended by the Task Force to Develop Performance Quality Measures for Managed Behavioral Healthcare Organizations (MBHOs). MHCC-specific performance reporting requires that each HMO provide information on the behavioral health providers serving the same geographic area that the health plan serves.

Mental illness affects approximately 57.6 million Americans 18 years or older (Journal of the American Medical Association, 2004). Because mental illness symptoms vary by diagnosis and stigma persists with behavioral disorders, only a small portion of the population is diagnosed. Without treatment, symptoms associated with the mental illness disorders can last for years, and could possibly lead to death by suicide or other causes. Two specific services that health plans can easily provide to prevent adverse behavioral health events are follow-up care after a hospital discharge and management of antidepressant medication. Managed care organizations and their MBHOs should make a practice of scheduling follow-up appointments when a patient is discharged and should also educate patients and practitioners about the importance of follow-up visits.

MBHOs are separate organizations that contract with health plans or employers to provide only mental health care and chemical dependency services. Health plans often contract with other companies for specialized services rather than provide them to their members directly. When health plans contract with another company to provide services, the health plan remains legally responsible for ensuring the quality of care provided by that contractor, the MBHO.

Utilization data for people who received behavioral health services via a separate contract between their employer and an MBHO or through a private arrangement are not included here.

Measures in Domain

- Follow-up After Hospitalization for Mental Illness: 7 day and 30 day
- Antidepressant Medication Management: Optimal Practitioner Contacts, 3 and 6 Months Treatment Phases
- Mental Health Utilization—Inpatient Discharges and Average Length of Stay
- Mental Health Utilization—Percentage of Members Receiving Inpatient, Day/Night Care, or Ambulatory Services
- Chemical Dependency Utilization—Inpatient Discharges and Average Length of Stay
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Identification of Alcohol and Other Drug Services
- Behavioral Health Care Provider Network

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Background

Mental illnesses such as depression, schizophrenia, and bipolar disorder are significant causes of disability in the United States. Mental disorders can lead to suicide, one of the United States' leading preventable causes of death. In some cases the severity of the symptoms can lead to hospitalization. To help ensure the benefits of hospitalization are sustained, patients should receive follow-up visits with a mental health practitioner shortly after hospital discharge. Contact within seven days is important to ensure the patient has the necessary supports to make the transition home and to help prevent hospital readmission during this period of high risk for relapse or decline. An outpatient visit with a mental health practitioner within 30 days of discharge can help the patient manage in the longer term. This may include medication adjustment and the development of psychological and social supports.

Studies have found that adequate case management following discharge is effective in reducing early re-hospitalization in depressed patients. Some strategies for improving follow-up care include: appointment confirmation at time of discharge, tracking, and communication with outside providers; recontacts of patients who do not keep their appointments; and review of follow-up care on a monthly basis to identify system problems (Quality Profiles, 2005).

Measure Definition

This measure shows:

- The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to *7 days* after hospital discharge.

- The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to *30 days* after hospital discharge.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes

No significant changes.

Star Performer

The 7-day and 30-day measures are included in the *Consumer Guide*; therefore, they are eligible for Star Performer designation. No plan received a Star Performer designation for the 30-day measure.

Notes

Several factors complicate calculating this measure and can lead to underreporting. When interpreting results, readers should consider the following:

- The eligible population for this measure is based on discharges and not members. It is possible for the denominator to contain multiple discharges for the same individual if the discharges occurred more than 30 days apart.
- Since hospitalizations for mental illness do not occur frequently, the number of people who should have received the services measured is often small.
- Mental health services are often not administered by HMO providers. Both HMOs and employers contract with external organizations, MBHOs, to provide mental health services. Therefore, HMOs do not always receive complete data from their vendors. Incomplete or missing data can often influence HMOs' ability to accurately calculate this measure. As indicated previously, HMOs are legally responsible for care provided by their contractors.

Results *(see Tables 86-87)*

- For the 7-day measure, rates ranged from 46% to 66%, with one plan receiving above average, five plans average, and one plan below average scores.
- For the 30-day measure, rates ranged from 65% to 80%, with two plans receiving above average, four plans average, and one plan below average scores.
- Comparison of the rates for the two measures showed that 73% of eligible members received a follow-up visit within 30 days, while only 55% of members who should have received care within 7 days of hospital discharge received early treatment. The 3-year trend showed an increase in the eligible members that are receiving timely follow-up care. Since 2003, the 30-day rate has increased two percentage points and the 7-day rate has increased five percentage points.
- One plan was a Star Performer for the 7-day measure.

Table 86

Follow-up After Hospitalization for Mental Illness, 7 Days, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**50%**	**53%**	**55%**	**5%**			
Aetna	55%	56%	58%	⇔	●	⊙	⊙
BlueChoice	26%	45%	55%	🡅	○	○	⊙
CIGNA	51%	54%	46%	⇔	⊙	⊙	○
Coventry	55%	47%	52%	⇔	⊙	○	⊙
*Kaiser Permanente	67%	65%	66%	⇔	●	●	●
M.D. IPA	55%	49%	55%	⇔	●	○	⊙
OCI	49%	54%	58%	🡅	⊙	⊙	⊙

Table 87

Follow-up After Hospitalization for Mental Illness, 30 Days, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**71%**	**70%**	**73%**	**2%**			
Aetna	74%	75%	76%	⇔	⊙	●	●
BlueChoice	67%	66%	72%	⇔	⊙	○	⊙
CIGNA	65%	67%	65%	⇔	○	⊙	○
Coventry	76%	65%	72%	⇔	●	⊙	⊙
Kaiser Permanente	80%	73%	73%	🡇	●	⊙	⊙
M.D. IPA	73%	72%	80%	🡅	⊙	⊙	●
OCI	72%	74%	75%	⇔	⊙	●	⊙

Legend:

Change 2003 – 2005

- 🡅 Plan rate increased significantly from 2003 to 2005
- ⇔ Plan rate *did not* change significantly from 2003 to 2005
- 🡇 Plan rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

ANTIDEPRESSANT MEDICATION MANAGEMENT

Background

Depression ranks high as a chronic condition encountered by primary care physicians. It is estimated that in the United States, 35.1 million people (14.7 percent of the population) will suffer from a depressive disorder in their lifetime (SAMHSA, 2004). Nationally, 19.3 million people (8.1 percent of the population) had a *major* depressive episode in 2003, including 2.2 million youths aged 12 to 17 and 17.1 million adults aged 18 or older. According to the National Institute of Mental Health, depressive disorders affect nearly twice as many women than men and have begun appearing more frequently in children and adolescents in the recent decade. A depressive disorder is an illness that involves the mood, thoughts, and body and symptoms can last for weeks, months, or years without treatment.

Many patients who have a moderate to severe case of depression are generally good candidates for treatment with antidepressant medication. However, antidepressants can trigger side effects and treatment must be monitored to ensure effectiveness. If pharmacological therapy is initiated, the American Medical Association defines three phases of treatment: acute, continuation, and maintenance.

Measure Definition

This measure assesses three different facets of successful pharmacological management of depression.

1. *Optimal Practitioner Contacts for Medication Management*: Percentage of plan members 18 years and older, newly-diagnosed with depression, and treated with antidepressant medication, who had at least three follow-up contacts with a primary care practitioner or mental health practitioner, at least one of which is with a prescribing practitioner, during an 84-day acute treatment phase.

2. *Effective Acute Phase Treatment*: Percentage of plan members 18 years and older, newly-diagnosed with depression, and treated with antidepressant medication, who remained on antidepressant medication during an 84-day acute treatment phase.

3. *Effective Continuation Phase Treatment*: Percentage of plan members 18 years and older, newly-diagnosed with depression, and treated with antidepressant medication, who remained on an antidepressant medication for at least 180 days.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes

In 2004, the Optimal Practitioner Contacts measure was changed to allow the use of non-mental health practitioner and telephone visits. The changes in specifications are expected to increase rates, and therefore, this measure is not trendable for 2003-2005.

Star Performer

Although this measure is not trendable for 2003-2005, as stated above, this measure is included the *Consumer Guide*; therefore, it is eligible for Star Performer designation.

Notes

Like the two measures for Follow-Up After Hospitalization for Mental Illness, some unique issues may affect these three results. Coordinating data collection may pose a large challenge. Five of the seven Maryland plans contract with an MBHO to provide behavioral health benefits to members. Not all employers contract with the health plan for behavioral health services. Prescription drug plans are also often separate from health plan membership. Even when the health plan holds the contract with other providers and can request data, integrating data from the plan's own providers and from outside contracts adds an additional step to data collection efforts and may result in the omission of some data.

Results *(see Tables 88-90)*

Optimal Practitioner Contacts for Medication Management:

- Rates ranged from 14% to 26%, with two plans receiving above average, three plans average, and two plans below average scores.
- One plan received a Star Performer designation.

Effective Acute Phase Treatment:

- From 2003 to 2005, the Maryland HMO/POS average increased three percentage points to 62%.
- Two of the seven plans reporting for all three years significantly improved their rate.
- In 2005, rates ranged from 55% to 68%, with two plans above average, four plans average, and one plan scored below average.
- One plan received a Star Performer designation.

Effective Continuation Phase Treatment:

- From 2003 to 2005, the Maryland HMO/POS average increased three percentage points to 43%.
- Three of the seven plans reporting for all three years significantly improved their rate.
- In 2005, rates ranged from 30% to 52%, with two plans receiving above average, three plans average, and two plans below average scores.
- One plan received a Star Performer designation.

Table 88

Antidepressant Medication Management, Optimal Practitioner Contacts						
	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2003	2004	2005	2003	2004	2005
Maryland HMO/POS Average	**23%**	**22%**	**19%**			
Aetna	21%	23%	18%	⊙	⊙	⊙
BlueChoice	17%	18%	14%	○	○	○
CIGNA	19%	23%	21%	⊙	⊙	⊙
Coventry	22%	23%	18%	⊙	⊙	⊙
Kaiser Permanente	16%	16%	15%	○	○	○
*M.D. IPA	33%	26%	26%	●	●	●
OCI	27%	24%	22%	●	⊙	●

Table 89

Antidepressant Medication Management, Effective Acute Phase Treatment, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2004	2003	2004	2005
Maryland HMO/POS Average	**59%**	**61%**	**62%**	**3%**			
Aetna	59%	63%	62%	⇔	⊙	⊙	⊙
BlueChoice	57%	64%	65%	🡅	⊙	●	●
CIGNA	57%	61%	63%	⇔	⊙	⊙	⊙
Coventry	59%	59%	55%	⇔	⊙	⊙	○
*Kaiser Permanente	63%	63%	68%	🡅	●	●	●
M.D. IPA	60%	57%	63%	⇔	⊙	○	⊙
OCI	59%	59%	61%	⇔	⊙	⊙	⊙

Table 90

Antidepressant Medication Management, Effective Continuation Phase Treatment							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**40%**	**43%**	**43%**	**3%**			
Aetna	41%	43%	46%	🡅	⊙	⊙	⊙
BlueChoice	32%	47%	48%	🡅	○	●	●
CIGNA	36%	49%	43%	⇔	⊙	●	⊙
Coventry	43%	41%	30%	🡇	⊙	⊙	○
*Kaiser Permanente	46%	46%	52%	🡅	●	●	●
M.D. IPA	39%	37%	40%	⇔	⊙	○	⊙
OCI	39%	40%	40%	⇔	⊙	○	○

Legend:

Change 2003 – 2005

🡅 Plan rate increased significantly from 2003 to 2005

⇔ Plan rate *did not* change significantly from 2003 to 2005

🡇 Plan rate decreased significantly from 2003 to 2005

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average

⊙ = Plan performed equivalent to the Maryland HMO/POS average

○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.
- *Star Performer—This designation indicates the plan achieved a better than average relative rate for this measure for three consecutive reporting years (2003–2005).

MENTAL HEALTH UTILIZATION—INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY

Measure Definition

This MHCC-specific performance measure, which is part of the HEDIS *Use of Services* domain, estimates how many hospitalizations for mental health disorders occurred during 2004 and how long patients stayed in the hospital, on average. The measure includes only members who had behavioral health coverage with their health plan. If the health plan contracts with another provider, the plan is responsible for collecting and reporting those data. Rates are per 1,000 members with mental health coverage. Data are not included here if members receive services outside their health plan, as a result of behavioral health services being excluded from their coverage by their health plan.

Notes

Ensuring the quality of behavioral health data from vendors and compiling it with internal behavioral service information has not been an area of plan strength. As a result, data completeness issues can decrease plan utilization rates.

Results *(see Table 91)*

- The Maryland HMO/POS average rate of hospitalizations for all mental disorders was 3.0 discharges per 1,000 members in 2005.
- The 2005 rates ranged from 2.0 discharges to 3.4 discharges per 1,000 members.
- Average length of stay ranged from 4.2 to 6.2 days per 1,000 members.

Table 91

Mental Health Utilization -- Inpatient Discharges and Average Length of Stay, 2005 Results		
	Discharges/1,000 Members	**ALOS (Days)**
Maryland HMO/POS Average	**3.0**	**5.6**
Aetna	3.0	6.2
BlueChoice	2.9	5.7
CIGNA	2.0	5.8
Coventry	3.2	4.2
Kaiser Permanente	3.3	5.7
M.D. IPA	3.4	5.9
OCI	3.4	5.5

MENTAL HEALTH UTILIZATION—PERCENTAGE OF MEMBERS RECEIVING ANY SERVICES

Measure Definition

This MHCC-specific performance measure, which is part of the HEDIS *Use of Services* domain, reports the portion of members who received the following types of mental health services:

- Inpatient hospital treatment
- Intermediate care (a level of intermediate care where a patient may live at home and visit a therapeutic institution during the day)
- Ambulatory treatment

This measure also provides information about access to mental health services. Rates are expressed as a percentage.

Results *(see Table 92)*

- Across Maryland HMOs, 5.13% of all members with behavioral health coverage received some type of behavioral health service in 2005.
- In 2005, rates ranged from 4.62% to 6.45%.

Rates for hospital treatment (inpatient), intermediate care, and ambulatory treatment are included in the report to facilitate comparison and analysis by plans, providers, and other organizations.

Table 92

Mental Health Utilization - Any Services, 2005 Results								
	Any		Inpatient		Intermediate		Ambulatory	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Maryland HMO/POS Average	**16,640**	**5.13%**	**774**	**0.24%**	**178**	**0.05%**	**16,220**	**5.01%**
Aetna	16,091	4.77%	776	0.23%	255	0.08%	15,908	4.72%
BlueChoice	31,910	6.45%	1,172	0.24%	270	0.05%	30,468	6.16%
CIGNA	5,805	4.62%	215	0.17%	12	0.01%	5,737	4.57%
Coventry	4,852	5.19%	231	0.25%	8	0.01%	4,787	5.12%
Kaiser Permanente	22,778	5.13%	1,109	0.25%	182	0.04%	22,433	5.05%
M.D. IPA	10,330	4.96%	538	0.26%	133	0.06%	10,103	4.85%
OCI	24,717	4.76%	1,376	0.26%	383	0.07%	24,104	4.64%

Note:

- The sum of the number of members who receive various services does not equal the number of members who received any service due to some members receiving more than one type of service.

CHEMICAL DEPENDENCY UTILIZATION – INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY

According to the Office of Applied Studies, Substance Abuse and Mental Health Services (SAMHSA) 22.5 million Americans aged 12 or older in 2004 were classified with past year substance dependence or abuse (9.4 percent of the population), which is about the same prevalence in 2002 and 2003. Of these, 3.4 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.9 million were dependent on or abused illicit drugs but not alcohol, and 15.2 million were dependent on or abused alcohol but not illicit drugs.

Measure Definition

This MHCC-specific performance measure, which is part of the HEDIS *Use of Services* domain, reports how many hospitalizations for chemical dependency occurred during 2004 and how long patients stayed in the hospital, on average. The single most common type of treatment sought is for alcohol dependence. The measure includes only members whose health care benefits include coverage for chemical dependence. Rates are per 1,000 members with chemical dependency coverage.

Notes

As is the case for all data related to behavioral health, the quality of data on use of chemical dependency services may reflect underreporting. Data collection problems are connected to how these services are delivered, often via contractors, or private arrangements, rather than through health plans.

Results *(see Table 93)*

- The Maryland HMO/POS average increased from 0.7 discharges per 1,000 members in 2004 to 0.8 discharges in 2005.
- In 2005, rates ranged from 0.4 discharges to 1.1 discharges per 1,000 members.
- The Maryland average HMO/POS average length of stay decreased slightly from 3.9 days in 2004 to 3.8 days in 2005, ranging from 3.2 days to 4.6 days.

Table 93

Chemical Dependency Utilization -- Inpatient Discharges and Average Length of Stay, 2005 Results		
	Discharges/1,000 Members	**ALOS (Days)**
Maryland HMO/POS Average	**0.8**	**3.8**
Aetna	0.8	4.6
BlueChoice	0.9	3.5
CIGNA	0.4	4.1
Coventry	0.8	3.2
Kaiser Permanente	1.1	4.4
M.D. IPA	0.7	3.5
OCI	1.0	3.3

IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES

Background

Substance abuse is costly to the individual, family, and health care system. Addiction to alcohol and drugs is associated with many diseases and disorders not to mention the countless accidents that occur as a result. According to the National Council on Alcohol and Drug Dependence, about 18 million Americans have alcohol problems and 5 to 6 million suffer from drug problems. The U. S. Preventive Services Task Force recommends screening and behavioral health counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings (AHRQ, 2005).

Measure Definition

This measure reports the number and percentage of members with an AOD claim. These claims contain a diagnosis of AOD abuse or dependence and one of the following AOD-related services during the measurement year:

- Inpatient hospital treatment
- Intermediate care
- Ambulatory treatment

Summary of Changes

No significant changes.

Results *(see Table 94)*

- Across Maryland HMOs, 0.68% of all members with substance abuse coverage had alcohol or other drug claims for services rendered in 2005.
- In 2005, rates ranged from 0.36% to 0.98%.

Rates for hospital treatment (inpatient), intermediate care, and ambulatory treatment are included in the report to facilitate comparison and analysis by plans, providers, and other organizations. There are minimal differences across plans, as rates for each level of care are less than 1%.

Table 94

Identification of Alcohol and Other Drug Services - Percentage of Members Receiving Services, 2005 Results

	Any Services		Inpatient Services		Intermediate Services		Ambulatory Services	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Maryland HMO/POS Average	**2,294**	**0.68%**	**670**	**0.21%**	**150**	**0.04%**	**1,823**	**0.53%**
Aetna	1,229	0.36%	204	0.06%	207	0.06%	1,095	0.32%
BlueChoice	4,827	0.98%	1,484	0.30%	378	0.08%	3,707	0.75%
CIGNA	529	0.42%	203	0.16%	20	0.02%	394	0.31%
Coventry	802	0.86%	274	0.29%	14	0.01%	606	0.65%
Kaiser Permanente	3,823	0.86%	686	0.15%	125	0.03%	3,600	0.81%
M.D. IPA	1,139	0.55%	477	0.23%	80	0.04%	746	0.36%
OCI	3,710	0.71%	1,362	0.26%	227	0.04%	2,610	0.50%

Note: The sum of the number of members who receive various services does not equal the number of members who received any service due to some members receiving more than one type of service.

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Background

Alcohol and other drug (AOD) use is a growing problem in the United States. It is estimated that 16.6 million Americans aged 12 or older in 2001 were classified with dependence on or abuse of either alcohol or illicit drugs (National Household Survey on Drug Abuse, 2001). The impact of addiction can be far reaching. Cardiovascular disease, stroke, cancer, HIV/AIDS, hepatitis, and lung disease can all be affected by drug and alcohol abuse. Some of the adverse effects occur when drugs are used at high doses or after prolonged use; however, some may occur after just one use (National Institute on Drug Abuse, 2004). According to the National Institute on Alcohol and Alcoholism, the cost of alcohol abuse on society is approximately $85 billion annually, while other drug use can cost approximately $47 billion.

With proper treatment alcohol and drug dependence can be overcome. Research has shown that treatment can improve both health and job performance. Research also supports not only the need for individuals to cease using the substance(s), but to also engage in ongoing treatment to prevent relapse.

Measure Definition

This measure assesses the degree to which plans initiate and engage members with a need for alcohol and other drug dependence services.

Initiation of Alcohol and Other Drug Dependence: The percentage of adults 18 years or older diagnosed with AOD dependence that had an inpatient AOD admission or outpatient service for AOD dependence and any additional AOD services within 14 days.

Engagement of Alcohol and Other Drug Dependence: The percentage of members who engaged in treatment with two additional AOD treatments within 30 days after initiating treatment.

Data Collection Methodology

This measure is collected using the administrative methodology.

Summary of Changes

No significant changes.

Results *(see Tables 95-96)*

Initiation of Alcohol and Other Drug Dependence

- The Maryland HMO/POS average increased from 35% in 2004 to 44% in 2005.
- In 2005, rates ranged from 35% to 51%, with four plans receiving above average, one plan average, and two plans below average scores.

Engagement of Alcohol and Other Drug Dependence

- The Maryland HMO/POS average decreased from 18% in 2004 to 14% in 2005.
- In 2005, rates ranged from 9% to 24%, with two plans receiving above average, four plans average, and one plan below average.

Table 95

Initiation of Alcohol and Other Drug Treatment				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**35%**	**44%**		
Aetna	47%	48%	●	●
BlueChoice	33%	36%	○	○
CIGNA	56%	35%	●	○
Coventry	39%	45%	●	⊙
Kaiser Permanente	29%	51%	○	●
M.D. IPA	20%	49%	○	●
OCI	22%	47%	○	●

Table 96

Initiation of Alcohol and Other Drug Treatment-Engagement				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2004	2005	2004	2005
Maryland HMO/POS Average	**18%**	**14%**		
Aetna	19%	13%	⊙	⊙
BlueChoice	20%	24%	●	●
CIGNA	24%	9%	●	○
Coventry	17%	12%	⊙	⊙
Kaiser Permanente	17%	16%	⊙	●
M.D. IPA	12%	13%	○	⊙
OCI	15%	14%	○	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan rate and the Maryland HMO/POS average for a given reporting year.

BEHAVIORAL HEALTH CARE PROVIDERS

Background

This measure was developed by MHCC to collect data on the number and types of behavioral providers available to members through their plan. Many health plans now contract with MBHOs to provide care to some or all of their members. These organizations, specializing in providing mental health and chemical dependency services, have their own network of physicians and other behavioral health practitioners. MBHOs can also have specific rules for accessing behavioral health services including the need for a referral, limits on coverage, and co-payments that may be different than the HMO's.

If a plan does not contract with an MBHO, the plan provides behavioral health services within its network of providers. When care is delivered and no problems arise, the contractual relationship between an HMO and an MBHO may be transparent to members. Obtaining referrals from their health plan for behavioral health services has been an area of great concern by members of HMOs.

Measure Definition

This MHCC-specific performance measure reports the number of providers for various disciplines in the behavioral health network and the percentage of network psychiatrists who are board-certified as of the close of business on December 31, 2004. Only providers who service members enrolled within the commercial product of the health plan are counted. Providers may be employed by the HMO, have a contractual relationship with the HMO, or have a contractual relationship with the MBHO responsible for managing and providing care for the HMO's enrollees. The provider types are:

- psychiatrists
- psychologists
- other behavioral health providers (includes certified professional counselors, social workers, nurse psychotherapists)

Results *(see Tables 97-98)*

The measure shows a comparison of the provider network available to members of the various plans. The number of providers available is compared for an equal number of members across each plan, providers per 1,000 members. A larger number of providers improves access to care by giving members more choices in who they see, appointment times, and locations.

The number of behavioral health providers in the MBHO and plan network as of December 31, 2004:

Psychiatrists (M.D.): The Maryland HMO/POS average for number of psychiatrists (M.D.) is 2.0 per 1,000 members. Rates ranged from 0.6 to 4.1 per 1,000 members.

Psychologists (Ph.D.): The Maryland HMO/POS average for number of psychologists (Ph.D.) is 2.7 per 1,000 members. Rates ranged from 1.1 to 8.2 per 1,000 members.

Other Providers: The Maryland HMO/POS average for number of other providers is 6.2 per 1,000 members. Rates ranged from 2.9 to 12.9 per 1,000 members.

Total Providers: The Maryland HMO/POS average for number of total providers is 10.9 per 1,000 members. Rates ranged from 4.7 to 25.2 per 1,000 members.

The percentage of psychiatrists who are board certified as of December 31, 2004:

Psychiatrists (M.D.)
Board Certification: The Maryland HMO/POS average for the percentage of psychiatrists who are board certified psychiatrists (M.D.) is 72%. Rates ranged from 60% to 76%.

Table 97

Health Plan	MBHO	Percentage of Psychiatrists Who are Board Certified
Maryland HMO/POS Average		**72%**
Aetna	Magellan Behavioral Health- King of Prussia Regional Service Center	73%
BlueChoice	Magellan Behavioral Health- Mid Atlantic Service Center	70%
CIGNA	CIGNA Behavioral Health- Chesapeake	67%
Conventry	United Behavioral Health- Atlanta Regional Care Center	76%
Kaiser Permanente**	**	73%
	APS Healthcare	60%
M.D. IPA	**	72%
OCI	**	71%

Table 98

Health Plan	MBHO	Number of Behavioral Health Providers in MBHO and Plan Network on 12/31/04 (per 1000 Members)*			
		Psychiatrists (M.D.)	Psychologists (Ph.D.)	Other Providers	Total Providers
Maryland HMO/POS Average		2.0	2.7	6.2	10.9
Aetna	Magellan Behavioral Health- King of Prussia Regional Service Center	1.3	1.6	5.4	8.3
BlueChoice	Magellan Behavioral Health- Mid Atlantic Service Center	1.0	1.3	4.7	7.0
CIGNA	CIGNA Behavioral Health	1.5	1.2	3.6	6.3
Conventry	United Behavioral Health- Chesapeake	4.1	8.2	12.9	25.2
Kaiser Permanente**	***	0.1	0.1	0.3	0.5
	APS Healthcare	0.5	1.1	2.7	4.3
M.D. IPA	***	4.0	3.7	9.5	17.2
OCI	***	1.8	1.7	4.2	7.7

- Number of providers is based upon the **service area** of the plan. The MBHO network may have a larger number of practitioners than reported in this report.

** Depending upon the locations of the member's personal physician, services are administered by either Kaiser Permanente directly or through an arrangement with APS Healthcare. Kaiser's behavioral health network is comprised of APS Healthcare and Kaiser practitioners.

*** Accredited health plan providing behavioral health services through practitioners in its network.

HEALTH PLAN
DESCRIPTIVE INFORMATION

HEALTH PLAN DESCRIPTIVE INFORMATION

Overview

This section contains results for the HEDIS *Health Plan Descriptive Information* measures that MHCC required Maryland commercial HMOs to report in 2005. It includes information on health plan structure, staffing, and enrollment. Although these are not performance measures, this background information will assist readers in interpreting performance measures and making informed choices among health plans.

Purchasers and consumers are interested in the qualifications of doctors in their health plan and member/enrollee patterns, which can reveal potential signs of instability. A sudden decrease in membership may indicate member dissatisfaction. Likewise, a sudden increase in membership due to merger/acquisition could suggest a potential future problem ensuring access to care and satisfaction to more members than a plan has capacity to handle. The following measures address these issues.

Measures in Domain

- Board Certification
- Total Enrollment

BOARD CERTIFICATION

Background

Board certification is often used as a proxy to measure physician quality. This measure does not directly measure the quality of the physician. Virtually all medical specialty boards certify physicians who complete additional training and pass an examination in that specialty. Board certification does show that the physician has an extended knowledge of a specialty that may be of importance to purchasers and consumers. Some physicians have valid reasons why they have not sought and obtained board certification. Board certification alone is not a guarantee of quality. A plan might have a lower percentage of board certified physicians if the plan has a higher proportion of older physicians who began their practice before board certification was established. Similarly, a plan's rate may be lower if the plan is located in a rural area where shortage of a particular type of physician is common.

Measure Definition

This measure reports the percentage of the following *physician* practitioners who are board certified:

- Primary care physician practitioners
- OB/GYN practitioners
- Pediatric practitioner specialists*
- All other practitioner specialists

Board certification refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association.

Summary of Changes

No significant changes.

***Physicians designated by the plan as providing pediatric-focused specialty care.**

Results *(see Table 99)*

Comparison of 2005 Maryland HMO/POS results across categories indicates that all provider groups show some variation of Board Certification rates by specialty ranging from 79% to 84% for OB/GYN Practitioners, Pediatric Practitioner Specialists, and Primary Care Practitioners (PCP). These measures are not reported in the *Consumer Guide*; therefore, plans cannot achieve Star Performer status for these measures.

Primary Care Physician Practitioners (PCP) (see Tables 99, 100)

- From 2003 to 2005, two of the seven plans reporting for all three years increased their rate. The Maryland HMO/POS average increased two percentage points over this period.
- In 2005, rates ranged from 80% to 93%, with two plans receiving above average, one plan average, and four plans below average scores.

OB/GYN Practitioners (see Tables 99, 101)

- From 2003 to 2005, only one out of seven plans reporting for all three years increased its rate. The Maryland HMO/POS average decreased one percentage point over this period.
- In 2005, rates ranged from 75% to 91%, with two plans receiving above average, two plans average, and three plans below average scores.

Pediatric Practitioner Specialists (see Tables 99, 102)

- From 2003 to 2005, only one out of seven plans reporting for all three years increased its rate. The Maryland HMO/POS average increased one percentage point over this period.
- In 2005, rates ranged from 64% to 100%, with four plans receiving above average, one plan average, and two plans below average scores.

Other Specialists (see Tables 99, 103)

- From 2003 to 2005, two out of the seven plans reporting for all three years increased their rate. The Maryland HMO/POS average increased two percentage points over this period.
- In 2005, rates ranged from 74% to 90%, with two plans receiving above average, one plan average, and four plans below average scores.

Overall Trends

- One plan significantly performed better than the Maryland HMO/POS average in all categories.
- While the three-year trend has consistently moved toward a more highly credentialed network in three out of four categories for one plan, the percentage of board certified OB/GYNs has declined for Maryland HMO/POS plans on average.

Table 99

Board Certification, 2005 Results								
	PCP		OB/GYN		Pediatric		Other Specialists	
Maryland HMO/POS Average	**84%**		**79%**		**81%**		**81%**	
Aetna	85%	●	81%	●	68%	○	75%	○
BlueChoice	80%	○	75%	○	81%	⊙	82%	⊙
CIGNA	81%	○	75%	○	64%	○	74%	○
Coventry	85%	⊙	78%	⊙	87%	●	87%	●
Kaiser Permanente	93%	●	91%	●	100%	●	90%	●
M.D. IPA	82%	○	77%	⊙	85%	●	81%	○
OCI	81%	○	77%	○	84%	●	80%	○

Table 100

Primary Care Practitioner, Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**82%**	**84%**	**84%**	**2%**			
Aetna	84%	83%	85%	⇔	●	⊙	●
BlueChoice	76%	77%	80%	⇑	○	○	○
CIGNA	83%	81%	81%	⇓	●	○	○
Coventry	89%	89%	85%	⇓	●	●	⊙
Kaiser Permanente	85%	92%	93%	⇑	●	●	●
M.D. IPA	83%	82%	82%	⇔	⊙	○	○
OCI	81%	80%	81%	⇔	○	○	○

Legend:

Change 2003-2005

- ⇑ Plan's rate increased significantly from 2003 to 2005
- ⇔ Plan's rate *did not* change significantly from 2003 to 2005
- ⇓ Plan's rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.

Table 101

OB/GYN Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**80%**	**79%**	**79%**	**-1%**			
Aetna	82%	80%	81%	⇔	⊙	⊙	●
BlueChoice	74%	73%	75%	⇔	○	○	○
CIGNA	77%	74%	75%	⇔	○	○	○
Coventry	90%	79%	78%	🡻	●	⊙	⊙
Kaiser Permanente	82%	90%	91%	🡹	⊙	●	●
M.D. IPA	82%	80%	77%	🡻	●	⊙	⊙
OCI	81%	79%	77%	🡻	⊙	⊙	○

Table 102

Pediatric Specialist Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**80%**	**79%**	**81%**	**1%**			
Aetna	61%	68%	68%	🡹	○	○	○
BlueChoice	80%	79%	81%	⇔	⊙	⊙	⊙
CIGNA	64%	63%	64%	⇔	○	○	○
Coventry	88%	89%	87%	⇔	●	●	●
Kaiser Permanente	97%	89%	100%	⇔	●	⊙	●
M.D. IPA	86%	84%	85%	⇔	●	●	●
OCI	86%	84%	84%	⇔	●	●	●

Legend:

Change 2003-2005

- 🡹 Plan's rate increased significantly from 2003 to 2005
- ⇔ Plan's rate *did not* change significantly from 2003 to 2005
- 🡻 Plan's rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.

Table 103

Other Specialist Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**79%**	**81%**	**81%**	**2%**			
Aetna	74%	76%	75%	↑	○	○	○
BlueChoice	81%	81%	82%	⇔	●	⊙	⊙
CIGNA	74%	73%	74%	⇔	○	○	○
Coventry	97%	89%	87%	↓	●	●	●
Kaiser Permanente	74%	85%	90%	↑	○	●	●
M.D. IPA	83%	82%	81%	↓	●	●	○
OCI	82%	81%	80%	↓	●	⊙	○

Legend:

Change 2003-2005

- ↑ Plan's rate increased significantly from 2003 to 2005
- ⇔ Plan's rate *did not* change significantly from 2003 to 2005
- ↓ Plan's rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.

TOTAL ENROLLMENT

Background

Enrollment information conveys the size of the population a health plan serves. Being aware of the size of each health plan may be useful in interpreting some results presented in previous sections. Although quality and health plan size do not have a direct association, changes in enrollment size can have a measurable impact upon member and provider satisfaction. A 1998 study conducted by Watson Wyatt and the National Association of Managed Care Physicians surveyed physicians about their attitudes toward MCOs. Questions that addressed the extent of recent changes in plan membership, management and ownership showed respondents prefer plans with relatively low physician and member turnover and do not favor plans that have recently merged with other MCOs. It seems reasonable that physicians would prefer predictability in their patient and carrier relationships, especially since American health care has undergone many rapid changes in recent years. Enrollment information is an additional piece of data for consumers and purchasers to consider in comparing health plans.

Based on another study of 740 HMOs conducted by Utah Hospitals & Health Systems Association (2000), an average of 18.9 percent members disenrolled per plan; an average of 10.2 percent were voluntary disenrollments; and an average of 18.3 percent were involuntary disenrollments. Plans with higher satisfaction enrollees had predominantly lower disenrollment rates, more enrollees likely to recommend plans to family or friends, fewer older enrollees, fewer male enrollees, and higher overall plan performance. To enhance the gaining and retaining of enrollees, plan administrators should closely monitor the various dimensions of satisfaction, such as services complement, quality of care, administrative efficiency, care management, enrollees' complaints, plan performance, appointment convenience, and waiting times.

Measure Definition

This measure shows the number of member years contributed by enrollees for each health plan in 2004. Member years are closely associated with the number of members in the health plan.

Notes

Enrollment figures are for each plan’s entire population for the age groups noted. This number includes Maryland residents and enrollees residing in service areas of Washington, D.C., Northern Virginia, Richmond, Delaware, Southern New Jersey, Southeastern Pennsylvania, and West Virginia.

Enrollment figures for all plans, except Kaiser, include membership in HMO and point of service products. Kaiser reports HEDIS rates based on the HMO product alone.

Results *(see Table 104)*

The total enrollment for Maryland commercial HMO/POS plans is estimated at 2.3 million, with the average plan having approximately 327,000 members. Plan membership ranges widely from 97,586 to 521,886.

Enrollment in Maryland commercial HMO/POS plan has remained stable from 2004 to 2005 with total enrollment increasing less than 1% for the seven plans reporting all three years. An increase was seen in three of the seven plans, Aetna, BlueChoice, and M.D. IPA. This marks the second year that both BlueChoice and M.D. IPA showed an increase in total enrollment.

Table 104

Total Enrollment (Member Years) in 2005														
	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	Total
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	2005	2004
Maryland HMO/POS Average	**49,417**	**47,704**	**97,121**	**60,402**	**71,311**	**131,713**	**43,433**	**48,192**	**91,625**	**3,553**	**3,329**	**6,883**	**327,341**	**324,266**
Maryland Total	**345,917**	**333,929**	**679,846**	**422,814**	**499,174**	**921,988**	**304,029**	**337,346**	**641,375**	**24,872**	**23,306**	**48,178**	**2,291,389**	**2,269,864**
Aetna	55,382	53,407	108,789	60,254	73,835	134,089	41,353	46,338	87,691	3,437	3,311	6,748	337,317	336,045
BlueChoice	69,211	66,806	136,017	103,522	122,755	226,277	61,016	68,968	129,984	1,273	1,142	2,415	494,693	433,457
CIGNA	23,853	23,096	46,949	31,782	34,627	66,409	18,564	18,668	37,232	886	684	1,570	152,160	177,517
Coventry	14,368	13,545	27,913	16,876	18,793	35,669	14,376	15,592	29,968	2,057	1,977	4,034	97,586	101,304
Kaiser Permanente	65,439	63,656	129,095	73,341	90,845	164,186	63,153	74,846	137,999	6,442	6,366	12,808	444,088	456,597
M.D. IPA	40,129	38,569	78,698	37,171	47,580	84,751	34,185	37,613	71,798	4,379	4,033	8,412	243,659	239,351
OCI	77,535	74,850	152,385	99,868	110,739	210,607	71,382	75,321	146,703	6,398	5,793	12,191	521,886	525,593

Enrollment data for 2004 are included for comparative purposes.

HEALTH PLAN STABILITY

HEALTH PLAN STABILITY

Overview

This section presents results for a measure in the HEDIS *Health Plan Stability* domain that MHCC required Maryland HMOs to report in 2005. When reviewing other aspects of health plan performance, past performance can be a good predictor of future performance, assuming a plan's structure and health care delivery systems remain reasonably stable.

In 2005, commercial plans in Maryland reported **Practitioner Turnover** as an indicator of stability.

PRACTITIONER TURNOVER

Background

The percentage of practitioners who leave a health plan may have implications for the quality of health care members receive. Although there is little evidence that high turnover has an impact on the quality of care for acute illnesses, several studies have shown that continuity of practitioners in treating chronic illnesses is desirable. In addition, for most patients, an on-going relationship increases their level of comfort with their physician. Some practitioner turnover is normal and expected due to individual changes in circumstances such as relocation or retirement. However, high rates of practitioner turnover may be a sign of practitioners' dissatisfaction with the health plan. Conversely, plans may end contracts with practitioners who are not adhering to the plan's administrative or health care standards.

Studies, as reported by the Pinnacle Health Group (2004), have shown that more than 10 percent of the physician work force changes jobs annually. Physician turnover has the potential to not only cost the health care industry hundreds of millions of dollars per year but also has the potential to have an effect on patients. The cost to recruit and replace primary care physicians averages about $250,000 per doctor and it is even more expensive to recruit sub-specialists or doctors to practice in rural and impoverished urban areas. According to the Agency for Healthcare Research and Quality, physician turnover can affect health care quality because it deprives patients of consistent caregivers who know them well and will serve as their advocates.

Measure Definition

This measure shows the percentage of primary care physicians (PCPs) affiliated with the health plan as of December 2003 who were <u>not</u> affiliated with the health plan as of December 2004.

Notes

For this measure, lower rates indicate better performance. Therefore, above average performance is based on achieving lower than average provider turnover rates.

This measure is affected by health plan mergers, acquisitions, and other marketplace changes. Any health plan that has undergone a recent organizational change is likely to have a higher than usual turnover rate. The higher rate is usually an adjustment to change and tends to stabilize in subsequent years.

Results *(see Table 105)*

- From 2003 to 2005, the Maryland HMO/POS average increased two percentage points to 9%, showing an overall decline in performance.
- Five of the seven plans reporting for all three years experienced decreases in their practitioner turnover rate, indicating greater stability.
- In 2005, practitioner turnover rates ranged from 5% to 31%, with six plans receiving above average scores for their low rate of turnover; while one plan received a below average score.

Table 105

Practioner Turnover PCP, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2003	2004	2005	Change 2003-2005	2003	2004	2005
Maryland HMO/POS Average	**7%**	**7%**	**9%**	**2%**			
Aetna	6%	5%	5%	⇔	●	●	●
BlueChoice	7%	6%	5%	↑	⊙	●	●
CIGNA	8%	6%	6%	↑	⊙	●	●
Coventry	8%	6%	6%	↑	⊙	●	●
Kaiser Permanente	8%	8%	31%	↓	⊙	⊙	○
M.D. IPA	9%	10%	6%	↑	○	○	●
OCI	9%	10%	6%	↑	○	○	●

Legend:

Change 2003 - 2005

- ↑ Plan's rate increased significantly from 2003 to 2005
- ⇔ Plan's rate *did not* change significantly from 2003 to 2005
- ↓ Plan's rate decreased significantly from 2003 to 2005

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ❍ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2003–2005" indicates a statistically significant change in a plan's absolute (actual) rate during this period.
- Relative rates represent statistically significant differences between an individual plan's rate and the Maryland HMO/POS average for a given reporting year.
- Since a higher rate is worse for this measure, the above/below average categories have been reversed, i.e., a lower than average turnover rate is indicated by a "filled circle".

EXTERNAL ACCREDITATION
&
FINANCIAL RATINGS

EXTERNAL ACCREDITATION & FINANCIAL RATINGS

Overview

Accreditation and financial ratings are other ways of assessing health plan quality. Accreditation is an independent external assessment of health plan quality by a review organization. The National Committee for Quality Assurance (NCQA) and the American Accreditation Healthcare Commission (URAC) accredit the health plans and managed behavioral healthcare organizations (MBHOs) in this report.

Each of the health care organizations (health plans and MBHOs) in this report has voluntary obtained accreditation through NCQA, URAC, or both. In Maryland, accreditation is not required for health plans or MBHOs.

A.M. Best rates the financial strength of health plans. A.M. Best assesses the ability of companies to meet their financial obligations through an evaluation of the company's balance sheets, operating performance, and business profile.

HEALTH PLAN ACCREDITATION

Table 106 identifies the accreditation status of each Maryland health plan and identifies the accrediting organization.

Table 106: Health Plan Accreditation Status

Health Plan	Accreditation*		
	Organization	Status	Expiration Date
Aetna	NCQA	Excellent	01/08
BlueChoice	NCQA	Excellent	12/07
CIGNA	NCQA	Excellent	10/06
Coventry	URAC	Full Accreditation	06/07
Kaiser Permanente	NCQA	Excellent	06/07
M.D. IPA	NCQA	Excellent	04/06
OCI	NCQA	Excellent	04/06

*Accreditation status as of August 2005.

NCQA Health Plan Accreditation

NCQA accreditation evaluates how well a health plan manages all or parts of its delivery system—physicians, hospitals, other providers, and administrative services—in order to continuously improve health care for its members. A team of physicians and managed care experts conducts on-site and off-site evaluations. The team reviews grievance procedures, physician evaluation processes, care management processes, preventive health efforts, medical record keeping, quality improvement, and performance on key aspects of clinical care such as immunization rates. In 2005, NCQA's accreditation program required plans to report performance results for 18 clinical care measures.

A national oversight committee of physicians analyzes the team's findings and assigns an accreditation level based on the plan's performance relative to NCQA standards and the plan's performance relative to other plans on selected HEDIS measures. The standards and performance measures that make up NCQA's accreditation program fall into the following categories: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living with Illness.

NCQA Accreditation Levels:

NCQA assigns health plans one of five possible accreditation levels based on the plan's performance:

- ***Excellent:*** Highest accreditation status granted to plans demonstrating levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS results that are in the highest range of national or regional performance.

- ***Commendable:*** Awarded to plans demonstrating levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement.

- ***Accredited:*** Health plans with this designation must meet most of NCQA's basic requirements for consumer protection and quality improvement.

- ***Provisional:*** Indicates that a health plan's service and clinical quality meet some, but not all of NCQA's basic requirements for consumer protection and quality improvement.

- ***Denied:*** Denied is an indication that a health plan did not meet NCQA's requirements during its review.

Pharmacy Management Standards (MHCC-specific Performance Measure)

Maryland plans accredited by NCQA have met NCQA standards for pharmaceutical management, including formulary development. In order to help ensure that plan drug formularies are fair and valid, formulary policies are reviewed under the pharmaceutical management standards for managed care organizations that choose to be accredited by NCQA. NCQA standards require a plan to have the following:

- A formulary that is based on sound clinical evidence;
- An annual review of the formulary with updates at least annually;
- The involvement of appropriate, actively practicing practitioners, including pharmacists, in the development and updating of the formulary;
- A policy of giving practitioners a copy of the formulary and notifying them of changes; and
- Exception policies that consider medically necessary exceptions to the formulary.

The following health plans accredited by NCQA and have met the pharmaceutical management standards described above: Aetna, BlueChoice, CIGNA, Kaiser Permanente, M.D. IPA, and OCI.

URAC Health Plan Accreditation

URAC's Health Plan Accreditation standards provide a comprehensive assessment of health plan performance, and apply to health care systems such as HMOs and fully integrated PPOs that provide a full range of health care services. URAC's Health Plan Accreditation standards include key quality benchmarks for network management, provider credentialing, utilization management, quality management, and improvement and consumer protection.

Organizations applying for accreditation participate in a review process involving several phases. The initial phase consists of completing the application forms and supplying supporting documentation. The remaining phases of the accreditation process cover a period of approximately three to six months. These phases include the following:

- ***Desktop Review:*** During the review process, the reviewer conducts an analysis of the applicant's documentation in relation to the URAC standards. The application package consists of formal policies and procedures, organizational charts, position descriptions, contracts, sample template letters, and program descriptions and plans for departments such as quality management and credentialing. Any pending issues require clarification from the applicant.
- ***Onsite Review:*** The accreditation review team conducts an onsite review after completing the desktop review to verify compliance with the standards. During this review, management is interviewed about the organization and staff is observed performing its duties. Education and quality management programs are reviewed in detail. During the onsite visit, URAC reviewers also share "best practices" and provide other helpful guidance.
- ***Committee Review:*** The last phase of review leading to a recommendation regarding the application involves examination by two URAC committees comprised of professionals from health care and other industry experts. The URAC Accreditation Committee review process consists of a written summary documenting findings of the desktop and onsite reviews and discussion among members. An accreditation recommendation is then forwarded to URAC's Executive Committee, which makes a final accreditation determination.
- ***Conditions of Accreditation:*** Organizations awarded full accreditation must remain compliant with URAC standards during the two-year accreditation cycle. URAC has a grievance procedure for investigation of complaints about an accredited company. Complaints may originate from consumers, providers, or regulators. After completing the complaint investigation, sanctions may be issued that range from a letter of reprimand to revocation of accreditation, depending on the nature and frequency of the violations.

URAC Accreditation Levels

URAC assigns health plans one of three possible accreditation levels based on the plan's performance:

- ***Full*:** Granted to applicants successfully meeting all requirements. Organizations are awarded a full two-year accreditation. An accreditation certificate is issued to each company site that participated in the accreditation review.

- ***Conditional*:** Granted to organizations that meet most of the standards but need to improve certain policies or procedures before achieving full compliance. URAC requires organizations with Conditional Accreditation to follow a plan to demonstrate full compliance and move to Full Accreditation within six months.

- ***Provisional:*** Granted to those organizations that have otherwise complied with all standards but have not been in operation long enough (less than 12 months) to demonstrate full compliance with the standards.

Organizations that are unable to meet URAC standards may be placed on corrective action status, denied accreditation, or choose to withdraw.

MBHO ACCREDITATION

Like health plans, MBHOs can apply for voluntary accreditation. Accreditation indicates that the MBHO has met the quality standards set by the accrediting organization. Maryland plans in this report have elected to become accredited by NCQA, URAC, or both.

Table 107 shows which plans use MBHOs to cover some or all of their members. The table also indicates each MBHO's accreditation status, the accrediting organization, and when current accreditation expires. Two plans provide behavioral health services through their own network of providers. Behavioral health services for these plans are not accredited separately from the health plan's accreditation.

Table 107: MBHO Accreditation Status and Behavioral Health Benefit

Health Plan	Name of MBHO(s)	Name of Accrediting Body*	Accreditation Status: Expiration Date	% of Members with Behavioral Health Benefit
Aetna	Magellan Behavioral Health-King of Prussia Regional Service Center	NCQA URAC	Full: Expires 6/06 Full: Expires 6/07	100
BlueChoice	Magellan Behavioral Health-Mid-Atlantic Service Center	NCQA URAC	Full: Expires 7/06 Full: Expires 6/07	100
CIGNA	CIGNA Behavioral Health-Chesapeake	NCQA URAC	Full: Expires 1/07 Full: Expires 11/06	82.5
Coventry	United Behavioral Health-Atlanta Regional Care Center	NCQA URAC	Full: Expires 1/07 Full: Expires 11/06	95.8
Kaiser Permanente	KPMAS **	NA	NA	100
	APS Healthcare	NCQA URAC	Provisional: Expires 11/05 Full: Expires 1/06	
M.D. IPA	NA-provided within M.D. IPA	NA	NA	85.5
OCI	NA-provided within OCI	NA	NA	99.5

*Accreditation is voluntary. Accreditation Status as of August 2005.

**Members have access to the same network of providers; however, depending upon the location of their personal physician, services will be administered by either Kaiser Permanente or by APS.

NCQA – National Committee for Quality Assurance
URAC – URAC/American Accreditation Healthcare Commission
For the most current information on accreditation status, visit www.ncqa.org and www.urac.org.

NCQA MBHO Accreditation

NCQA's Managed Behavioral Healthcare Organization Accreditation program was launched in 1996. Since then, NCQA's MCO and MBHO Accreditation programs have become closely aligned, with nearly identical sets of standards applying to both types of organizations. Both accreditation programs seek to promote access to behavioral health care and coordination between medical and behavioral health professionals.

In NCQA's MBHO Accreditation Program, an existing standard requires that an MBHO annually monitor and evaluate at least two of the preventive behavioral health screening and educational interventions offered to its covered population. The categories of preventive interventions listed in the standard are adapted from the Institute of Medicine's *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research,* 1994. This publication lists a number of illustrative preventive interventions for the various age and population categories.

URAC MBHO Accreditation

MBHOs, like other integrated health care delivery systems, may choose to undergo a full review of their operations or have individual components reviewed for accreditation. URAC's Health Plan Standards program assesses an organization and assigns an accreditation level based on its performance as compared to the defined standards. This process consists of the same multi-phase review described in the previous section, Health Plan Accreditation. A range of accreditation programs is available through URAC that permit a review of a segment of the operations. The Health Utilization Management Standards is an example of an accreditation module managed care organizations, such as MBHOs, select to demonstrate they have the appropriate structures and procedures to promote quality care when making medical necessity determinations.

A.M. BEST'S FINANCIAL RATINGS

A.M. Best's financial strength ratings provide an independent opinion on the health insurance organization's ability to meet its obligations to its membership through an evaluation of the organization's balance sheet strength, operating performance, and business profile. Information on plan financial strength from A.M. Best can help purchasers and consumers make more informed health care purchasing decisions.

Table 108 below shows the A.M. Best financial rating of each Maryland health plan.

Table 108: Health Plan Financial Rating

Health Plan	A.M. Best Financial Rating*
Aetna	A Excellent (A.M. Best ID# 68550)
BlueChoice	B+ Very Good pd (A.M. Best ID# 68605)
CIGNA	A- Excellent (A.M. Best ID# 68871)
Coventry	B+ Very Good (A.M. Best ID# 68687)
Kaiser Permanente	B+ Very Good pd (A.M. Best ID# 68551)
M.D. IPA	A Excellent u (A.M. Best ID# 68606)
OCI	A Excellent u (A.M. Best ID# 68764)

*A.M. Best Financial Rating as of August 2005.
Ratings Modifiers: u Under Review; pd Public Data
For the most current information on financial ratings, visit www.ambest.com

A.M. Best Analysis

At the HMO's or insurance company's request, A.M. Best's analysts review detailed financial statements, interview senior management, and analyze data and information leading to an assignment of a financial strength rating following a committee review process. All health insurance companies are formally evaluated once every 12 months and they are subject to review following any significant event (e.g., catastrophe, unexpected changes to earnings or capital, management and changes in ownership).

Analysis may also be conducted on a non-interactive basis, in which case A.M. Best assigns the rating on a comprehensive review of the regulatory filings, publicly available data, and other public information. This type of rating is denoted as Public Data (pd).

The Best's Rating scale is comprised of 16 individual ratings, grouped into 10 categories. They consist of three **Secure** categories: Superior, Excellent, and Very Good; and seven **Vulnerable** categories: Fair, Marginal, Weak, Poor, Under Regulatory Supervision, In Liquidation, and Rating Suspended. A rating modifier can be assigned to indicate that a Best's Rating may be subject to near-term change (under review) and that a company did not subscribe to Best's interactive rating process (public data).

Secure ratings indicate that an insurer has a strong or good ability to meet its obligations to members and policyholders; and it maintains a level of financial strength that can withstand unfavorable changes in the business, economic, or regulatory environment. Vulnerable ratings tend to present progressively higher risks. Public data ratings incorporate analysis of balance sheet strength, operating performance, and business profile; however, the analysis does not generally involve interaction with company management.

For non-rated (NR) companies, a condition exists that makes it difficult for A.M. Best to develop an opinion on the company's balance sheet strength and operating performance. Generally, these companies do not qualify for a Best's Rating because of limited financial information, small level of surplus, lack of sufficient operating experience, or due to their dormant or run-off status. Unrated companies are assigned to one of five "Not Rated" categories.

Definitions of Best's Ratings and Not Rated (NR) Categories

Secure Best's Ratings:

***A++ and A+ (Superior)*:** Assigned to companies that have, in A.M. Best's opinion, a superior ability to meet their ongoing obligations to policyholders.

A and A- (Excellent): Assigned to companies that have, in A.M. Best's opinion, an excellent ability to meet their ongoing obligations to policyholders.

B++ and B+ (Very Good): Assigned to companies that have, in A.M. Best's opinion, a good ability to meet their ongoing obligations to policyholders.

Vulnerable Best's Ratings:

B and B- (Fair): Assigned to companies that have, in A.M. Best's opinion, a fair ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.

C++ and C+ (Marginal): Assigned to companies that have, in A.M. Best's opinion, a marginal ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.

C and C- (Weak): Assigned to companies that have, in A.M. Best's opinion, a weak ability to meet their current obligations to policyholders, but are financially very vulnerable to adverse changes in underwriting and economic conditions.

D (Poor): Assigned to companies, that in A.M. Best's opinion, may not have an ability to meet their current obligations to policyholders and are financially extremely vulnerable to adverse changes in underwriting and economic conditions.

E (Under Regulatory Supervision): Assigned to companies (and possibly their subsidiaries/affiliates) placed by an insurance regulatory authority under a significant form of supervision, control, or restraint whereby they are no longer allowed to conduct normal ongoing insurance operations. This would include conservatorship or rehabilitation, but does not include liquidation. It may also be assigned to companies issued cease and desist orders by regulators outside their home state or country.

F (In Liquidation): Assigned to companies that have been placed under an order of liquidation by a court of law or whose owners have voluntarily agreed to liquidate the company. Note: Companies that voluntarily liquidate or dissolve their charters are generally not insolvent.

S (Rating Suspended): Assigned to rated companies that have experienced sudden and significant events affecting their balance sheet strength or operating performance whose rating implications cannot be evaluated due to a lack of timely or adequate information.

APPENDIX A

HEALTH PLAN PERFORMANCE BY MEASURE

HEALTH PLAN PERFORMANCE BY MEASURE

This appendix contains plan results sorted by score for selected measures to show which plans performed best in each category of care. The measures were based on the eligible measures that were included in the above-average scores calculation described in the *Summary of Performance* section.

Effectiveness of Care
Plan Performance by Measure

Childhood Immunization Status Combination 2 2005 Results		
Maryland HMO/POS Average	**77%**	
Kaiser Permanente	86%	●
Coventry	81%	⊙
CIGNA	81%	⊙
BlueChoice	75%	⊙
M.D. IPA	75%	⊙
OCI	72%	○
Aetna	71%	○

Adolescent Immunization Status Combination 2 2005 Results		
Maryland HMO/POS Average	**53%**	
Kaiser Permanente	71%	●
Coventry	56%	⊙
Aetna	55%	⊙
CIGNA	54%	⊙
BlueChoice	50%	⊙
OCI	44%	○
M.D. IPA	42%	○

Appropriate Testing for Children with Pharyngitis, 2005 Results		
Maryland HMO/POS Average	**78%**	
Kaiser Permanente	89%	●
BlueChoice	82%	●
CIGNA	78%	⊙
OCI	76%	○
M.D. IPA	75%	○
Aetna	74%	○
Coventry	72%	○

Appropriate Treatment for Children with Upper Respiratory Infection, 2005 Results		
Maryland HMO/POS Average	**89%**	
M.D. IPA	95%	●
OCI	94%	●
Coventry	90%	⊙
BlueChoice	90%	●
CIGNA	87%	○
Kaiser Permanente	85%	○
Aetna	82%	○

Chlamydia Screening Total (Ages 16-25) 2005 Results		
Maryland HMO/POS Average	**42%**	
Kaiser Permanente	78%	●
Coventry	38%	○
Aetna	38%	○
BlueChoice	37%	○
M.D. IPA	36%	○
CIGNA	36%	○
OCI	32%	○

Controlling High Blood Pressure 2005 Results		
Maryland HMO/POS Average	**66%**	
CIGNA	79%	●
Kaiser Permanente	73%	●
BlueChoice	70%	⊙
Aetna	67%	⊙
Coventry	65%	⊙
M.D. IPA	55%	○
OCI	53%	○

Effectiveness of Care
Plan Performance by Measure

Beta-Blocker Treatment After Heart Attack 2005 Results		
Maryland HMO/POS Average	**96%**	
Coventry	100%	●
Kaiser Permanente	100%	●
BlueChoice	97%	⊙
CIGNA	97%	⊙
Aetna	96%	⊙
M.D. IPA	92%	○
OCI	88%	○

Persistent Beta-Blocker After Heart Attack 2005 Results		
Maryland HMO/POS Average	**66%**	
M.D. IPA	80%	●
Kaiser Permanente	75%	●
OCI	74%	●
Aetna	66%	⊙
CIGNA	64%	⊙
BlueChoice	59%	○
Coventry	44%	○

Cholesterol Management, Cholesterol (LDL-C) Screening, 2005 Results		
Maryland HMO/POS Average	**81%**	
CIGNA	85%	⊙
OCI	85%	●
M.D. IPA	82%	⊙
BlueChoice	82%	⊙
Coventry	81%	⊙
Kaiser Permanente	78%	○
Aetna	76%	○

Cholesterol Management, Cholesterol (LDL-C) < 100mg/dL Control, 2005 Results		
Maryland HMO/POS Average	**56%**	
OCI	61%	●
Kaiser Permanente	60%	●
BlueChoice	57%	⊙
CIGNA	56%	⊙
M.D. IPA	55%	⊙
Aetna	52%	⊙
Coventry	49%	○

Cholesterol Management, Cholesterol (LDL-C) < 130 mg/dL Control, 2005 Results		
Maryland HMO/POS Average	**72%**	
OCI	79%	●
CIGNA	76%	⊙
BlueChoice	73%	⊙
Kaiser Permanente	72%	⊙
M.D. IPA	69%	⊙
Coventry	67%	⊙
Aetna	67%	○

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Testing, 2005 Results		
Maryland HMO/POS Average	**85%**	
CIGNA	90%	●
Aetna	86%	⊙
Kaiser Permanente	85%	⊙
M.D. IPA	85%	⊙
Coventry	84%	⊙
OCI	83%	⊙
BlueChoice	82%	⊙

Effectiveness of Care
Plan Performance by Measure

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Control, 2005 Results		
Maryland HMO/POS Average	**70%**	
Kaiser Permanente	77%	●
CIGNA	76%	●
M.D. IPA	73%	⊙
OCI	70%	⊙
Aetna	67%	⊙
Coventry	66%	⊙
BlueChoice	59%	○

Comprehensive Diabetes Care, Cholesterol (LDL-C) Testing, 2005 Results		
Maryland HMO/POS Average	**91%**	
Aetna	93%	●
CIGNA	93%	⊙
BlueChoice	91%	⊙
Coventry	91%	⊙
Kaiser Permanente	91%	⊙
M.D. IPA	89%	⊙
OCI	88%	⊙

Comprehensive Diabetes Care, Cholesterol (LDL-C) <100mg/dL Control, 2005 Results		
Maryland HMO/POS Average	**45%**	
Kaiser Permanente	55%	●
OCI	47%	⊙
CIGNA	47%	⊙
M.D. IPA	46%	⊙
BlueChoice	44%	⊙
Coventry	40%	○
Aetna	38%	○

Comprehensive Diabetes Care, Cholesterol (LDL-C) <130mg/dL Control, 2005 Results		
Maryland HMO/POS Average	**69%**	
Kaiser Permanente	77%	●
CIGNA	71%	⊙
M.D. IPA	71%	⊙
OCI	70%	⊙
BlueChoice	69%	⊙
Aetna	66%	⊙
Coventry	63%	○

Comprehensive Diabetes Care, Eye Exams 2005 Results		
Maryland HMO/POS Average	**55%**	
Kaiser Permanente	66%	●
M.D. IPA	62%	●
BlueChoice	55%	⊙
Coventry	55%	⊙
CIGNA	51%	⊙
Aetna	50%	○
OCI	48%	○

Comprehensive Diabetes Care, Monitoring Diabetic Nephropathy, 2005 Results		
Maryland HMO/POS Average	**53%**	
Kaiser Permanente	70%	●
CIGNA	61%	●
Coventry	55%	⊙
BlueChoice	52%	⊙
Aetna	46%	○
M.D. IPA	45%	○
OCI	40%	○

Effectiveness of Care
Plan Performance by Measure

Comprehensive Diabetes Care MHCC- Specific Combination Rating, 2005 Results		
Maryland HMO/POS Average	**21%**	
Kaiser Permanente	43%	●
CIGNA	24%	⊙
BlueChoice	19%	⊙
Aetna	17%	○
M.D. IPA	16%	○
Coventry	15%	○
OCI	12%	○

Use of Appropriate Medications for People With Asthma (Ages 5-17 Years), 2005 Results		
Maryland HMO/POS Average	**73%**	
BlueChoice	81%	●
Coventry	76%	⊙
CIGNA	73%	⊙
OCI	72%	⊙
M.D. IPA	70%	○
Aetna	69%	○
Kaiser Permanente	68%	○

Use of Appropriate Medications for People With Asthma (Ages 18-56 Years), 2005 Results		
Maryland HMO/POS Average	**76%**	
BlueChoice	85%	●
Kaiser Permanente	79%	⊙
OCI	76%	⊙
Coventry	75%	⊙
CIGNA	74%	⊙
Aetna	74%	○
M.D. IPA	72%	○

Flu Shots for Adults Ages 50-64 2005 Results		
Maryland HMO/POS Average	**39%**	
Aetna	48%	●
Kaiser Permanente	45%	●
M.D. IPA	42%	⊙
OCI	38%	⊙
BlueChoice	36%	⊙
Coventry	36%	⊙
CIGNA	30%	○

Colorectal Cancer Screening 2005 Results		
Maryland HMO/POS Average	**53%**	
BlueChoice	62%	●
M.D. IPA	55%	●
CIGNA	53%	⊙
Kaiser Permanente	50%	○
OCI	50%	○
Aetna	49%	○
Coventry	49%	○

Breast Cancer Screening 2005 Results		
Maryland HMO/POS Average	**73%**	
Coventry	78%	●
M.D. IPA	76%	⊙
Kaiser Permanente	75%	⊙
CIGNA	74%	⊙
BlueChoice	70%	⊙
OCI	70%	⊙
Aetna	70%	⊙

Effectiveness of Care
Plan Performance by Measure

Cervical Cancer Screening 2005 Results		
Maryland HMO/POS Average	**83%**	
Aetna	85%	⊙
CIGNA	83%	⊙
M.D. IPA	83%	⊙
BlueChoice	83%	⊙
Kaiser Permanente	83%	⊙
Coventry	82%	⊙
OCI	81%	⊙

Advising Smokers to Quit 2005 Results		
Maryland HMO/POS Average	**73%**	
M.D. IPA	81%	●
BlueChoice	76%	⊙
CIGNA	74%	⊙
Coventry	73%	⊙
Kaiser Permanente	72%	⊙
Aetna	69%	⊙
OCI	67%	⊙

Discussing Smoking Cessation Medications 2005 Results		
Maryland HMO/POS Average	**41%**	
M.D. IPA	50%	●
Aetna	42%	⊙
BlueChoice	42%	⊙
Coventry	41%	⊙
OCI	40%	⊙
CIGNA	38%	⊙
Kaiser Permanente	33%	○

Discussing Smoking Cessation Strategies 2005 Results		
Maryland HMO/POS Average	**41%**	
M.D. IPA	54%	●
CIGNA	45%	⊙
Aetna	39%	⊙
OCI	39%	⊙
BlueChoice	39%	⊙
Kaiser Permanente	37%	⊙
Coventry	34%	○

Access/Availability of Care
Plan Performance by Measure

Adults' Access to Preventive/Ambulatory Health Services (Ages 20-64), 2005 Results		
Maryland HMO/POS Average	**93%**	
Coventry	96%	●
Kaiser Permanente	95%	●
M.D. IPA	94%	●
CIGNA	93%	○
BlueChoice	93%	○
OCI	92%	○
Aetna	92%	○

Children's Access to Primary Care Practitioners (12- 24 Months), 2005 Results		
Maryland HMO/POS Average	**97%**	
Coventry	98%	●
Aetna	98%	●
OCI	98%	⊙
Kaiser Permanente	97%	⊙
M.D. IPA	97%	⊙
BlueChoice	96%	○
CIGNA	96%	○

Children's Access to Primary Care Practitioners (25 Months-6 Years), 2005 Results		
Maryland HMO/POS Average	**89%**	
Coventry	92%	●
Kaiser Permanente	90%	●
Aetna	90%	●
BlueChoice	90%	⊙
CIGNA	89%	⊙
OCI	87%	○
M.D. IPA	87%	○

Children's Access to Primary Care Practitioners (7-11 years), 2005 Results		
Maryland HMO/POS Average	**90%**	
Coventry	93%	●
Kaiser Permanente	91%	●
CIGNA	90%	●
BlueChoice	90%	●
Aetna	88%	○
M.D. IPA	88%	○
OCI	87%	○

Adolescents' Access to Primary Care Practitioners (12-19 years), 2005 Results		
Maryland HMO/POS Average	**86%**	
Kaiser Permanente	89%	●
Coventry	88%	●
CIGNA	87%	●
BlueChoice	86%	●
M.D. IPA	83%	○
OCI	83%	○
Aetna	82%	○

Well-Child Visits for Infants and Children Composite, 2005 Results		
Maryland HMO/POS Average	**71%**	
Coventry	77%	●
CIGNA	74%	●
BlueChoice	73%	●
M.D. IPA	73%	⊙
OCI	71%	⊙
Aetna	66%	○
Kaiser Permanente	63%	○

Access/Availability of Care
Plan Performance by Measure

Adolescent Well-Care Visits 2005 Results		
Maryland HMO/POS Average	38%	
BlueChoice	42%	●
Coventry	40%	●
Aetna	38%	⊙
M.D. IPA	38%	⊙
CIGNA	38%	⊙
Kaiser Permanente	36%	○
OCI	36%	⊙

Prenatal and Postpartum Care, Prenatal 2005 Results		
Maryland HMO/POS Average	92%	
CIGNA	96%	●
BlueChoice	95%	●
Kaiser Permanente	94%	⊙
Aetna	94%	⊙
Coventry	92%	⊙
M.D. IPA	88%	○
OCI	87%	○

Prenatal and Postpartum Care, Postpartum 2005 Results		
Maryland HMO/POS Average	83%	
CIGNA	87%	●
Kaiser Permanente	87%	●
Aetna	82%	⊙
Coventry	82%	⊙
BlueChoice	82%	⊙
M.D. IPA	80%	⊙
OCI	78%	○

Satisfaction with the Experience of Care
Plan Performance by Measure

Rating of Health Plan 2005 Results				
	Rating 0-6	**Rating 7-8**	**Rating 9-10**	**2005 Category**
Maryland HMO/POS Average	**23%**	**41%**	**36%**	
M.D. IPA	17%	42%	41%	●
Kaiser Permanente	23%	37%	40%	⊙
OCI	22%	39%	39%	⊙
Coventry	20%	42%	38%	⊙
BlueChoice	22%	42%	35%	⊙
CIGNA	26%	41%	32%	○
Aetna	28%	43%	30%	○

Recommending Plan to Friends/Family 2005 Results					
	Definitely Not	**Probably Not**	**Probably Yes**	**Definitely Yes**	**2005 Category**
Maryland HMO/POS Average	**5%**	**9%**	**48%**	**38%**	
Kaiser Permanente	5%	10%	37%	47%	●
M.D. IPA	2%	6%	46%	46%	●
BlueChoice	4%	8%	49%	39%	⊙
Coventry	4%	7%	52%	38%	⊙
OCI	6%	8%	49%	37%	⊙
Aetna	6%	9%	53%	33%	○
CIGNA	7%	13%	52%	28%	○

Satisfaction with the Experience of Care
Plan Performance by Measure

Few Consumer Complaints 2005 Results			
	Yes, Did Complain	No, Did Not Complain	2005 Category
Maryland HMO/POS Average	**14%**	**86%**	
OCI	12%	88%	⊙
Aetna	12%	88%	⊙
Kaiser Permanente	13%	87%	⊙
Coventry	13%	87%	⊙
BlueChoice	14%	86%	⊙
M.D. IPA	16%	84%	⊙
CIGNA	16%	84%	⊙

Health Plan Customer Service 2005 Results				
	Big Problem	Small Problem	Not a Problem	2005 Category
Maryland HMO/POS Average	**8%**	**19%**	**73%**	
M.D. IPA	4%	17%	79%	●
OCI	6%	18%	77%	⊙
Aetna	8%	18%	73%	⊙
Kaiser Permanente	11%	17%	72%	⊙
Coventry	9%	19%	71%	⊙
CIGNA	9%	21%	70%	⊙
BlueChoice	11%	20%	69%	○

Satisfaction with the Experience of Care
Plan Performance by Measure

Getting Needed Care 2005 Results				
	Big Problem	Small Problem	Not a Problem	2005 Category
Maryland HMO/POS Average	**7%**	**15%**	**77%**	
Coventry	4%	10%	86%	●
BlueChoice	7%	14%	78%	⊙
Kaiser Permanente	9%	14%	77%	⊙
M.D. IPA	6%	18%	76%	⊙
OCI	9%	16%	76%	⊙
CIGNA	8%	17%	75%	⊙
Aetna	7%	19%	73%	○

Getting Care Quickly 2005 Results				
	Sometimes/ Never	Usually	Always	2005 Category
Maryland HMO/POS Average	**25%**	**31%**	**44%**	
Coventry	19%	32%	49%	●
OCI	26%	30%	44%	⊙
BlueChoice	27%	30%	43%	⊙
Kaiser Permanente	26%	31%	43%	⊙
CIGNA	25%	32%	43%	⊙
Aetna	28%	30%	42%	⊙
M.D. IPA	26%	32%	42%	⊙

Satisfaction with the Experience of Care
Plan Performance by Measure

How Well Doctors Communicate 2005 Results				
	Sometimes/ Never	Usually	Always	2005 Category
Maryland HMO/POS Average	**10%**	**30%**	**60%**	
OCI	8%	27%	64%	●
Coventry	9%	27%	64%	●
CIGNA	9%	29%	62%	⊙
BlueChoice	11%	28%	60%	⊙
Aetna	12%	31%	57%	⊙
M.D. IPA	10%	35%	55%	○
Kaiser Permanente	10%	35%	55%	○

Rating of Health Care 2005 Results				
	Rating 0-6	Rating 7-8	Rating 9-10	2005 Category
Maryland HMO/POS Average	**14%**	**40%**	**45%**	
Coventry	10%	39%	51%	●
BlueChoice	14%	38%	48%	⊙
OCI	16%	39%	45%	⊙
Kaiser Permanente	16%	40%	44%	⊙
M.D. IPA	12%	44%	44%	⊙
CIGNA	16%	41%	43%	⊙
Aetna	16%	42%	41%	⊙

Behavioral Health Care
Plan Performance by Measure

Follow-up After Hospitalization for Mental Illness 7 Days, 2005 Results		
Maryland HMO/POS Average	**55%**	
Kaiser Permanente	66%	●
Aetna	58%	⊙
OCI	58%	⊙
M.D. IPA	55%	⊙
BlueChoice	55%	⊙
Coventry	52%	⊙
CIGNA	46%	○

Follow-up After Hospitalization for Mental Illness 30 Days, 2005 Results		
Maryland HMO/POS Average	**73%**	
M.D. IPA	80%	●
Aetna	76%	●
OCI	75%	⊙
Kaiser Permanente	73%	⊙
Coventry	72%	⊙
BlueChoice	72%	⊙
CIGNA	65%	○

Antidepressant Medication Management Optimal Practitioner Contacts, 2005 Results		
Maryland HMO/POS Average	**19%**	
M.D. IPA	26%	●
OCI	22%	●
CIGNA	21%	⊙
Aetna	18%	⊙
Coventry	18%	⊙
Kaiser Permanente	15%	○
BlueChoice	14%	○

Antidepressant Medication Management Effective Acute Phase Treatment, 2005 Results		
Maryland HMO/POS Average	**62%**	
Kaiser Permanente	68%	●
BlueChoice	65%	●
CIGNA	63%	⊙
M.D. IPA	63%	⊙
Aetna	62%	⊙
OCI	61%	⊙
Coventry	55%	○

Antidepressant Medication Management Effective Continuation Phase, 2005 Results		
Maryland HMO/POS Average	**43%**	
Kaiser Permanente	52%	●
BlueChoice	48%	●
Aetna	46%	⊙
CIGNA	43%	⊙
M.D. IPA	40%	⊙
OCI	40%	○
Coventry	30%	○

Initiation of Alcohol and Other Drug Treatment 2005 Results		
Maryland HMO/POS Average	**44%**	
Kaiser Permanente	51%	●
M.D. IPA	49%	●
Aetna	48%	●
OCI	47%	●
Coventry	45%	⊙
BlueChoice	36%	○
CIGNA	35%	○

Behavioral Health Care
Plan Performance by Measure

Initiation of Alcohol and Other Drug Treatment-Engagement, 2005 Results		
Maryland HMO/POS Average	**14%**	
BlueChoice	24%	●
Kaiser Permanente	16%	●
OCI	14%	⊙
Aetna	13%	⊙
M.D. IPA	13%	⊙
Coventry	12%	⊙
CIGNA	9%	○

Health Plan Descriptive Information
Plan Performance by Measure

PCP Board Certification 2005 Results		
Maryland HMO/POS Average	**84%**	
Kaiser Permanente	93%	●
Aetna	85%	●
Coventry	85%	⊙
M.D. IPA	82%	○
CIGNA	81%	○
OCI	81%	○
BlueChoice	80%	○

OB/GYN Board Certification 2005 Results		
Maryland HMO/POS Average	**79%**	
Kaiser Permanente	91%	●
Aetna	81%	●
Coventry	78%	⊙
M.D. IPA	77%	⊙
OCI	77%	○
CIGNA	75%	○
BlueChoice	75%	○

Pediatric Board Certification 2005 Results		
Maryland HMO/POS Average	**81%**	
Kaiser Permanente	100%	●
Coventry	87%	●
M.D. IPA	85%	●
OCI	84%	●
BlueChoice	81%	⊙
Aetna	68%	○
CIGNA	64%	○

Other Board Certification 2005 Results		
Maryland HMO/POS Average	**81%**	
Kaiser Permanente	90%	●
Coventry	87%	●
BlueChoice	82%	⊙
M.D. IPA	81%	○
OCI	80%	○
Aetna	75%	○
CIGNA	74%	○

Health Plan Stability
Plan Performance by Measure

Practioner Turnover PCP 2005 Results		
Maryland HMO/POS Average	**9%**	
Kaiser Permanente	31%	○
M.D. IPA	6%	●
CIGNA	6%	●
Coventry	6%	●
OCI	6%	●
Aetna	5%	●
BlueChoice	5%	●

APPENDIX B

METHODS FOR DATA ANALYSES

METHODS FOR DATA ANALYSES

Methodology to Compare Plan Performance

For each HEDIS measure, CAHPS question, and CAHPS composite, a score is computed for each plan, and the mean value is computed for all of the plans as a group. Each score or mean is expressed as a percentage with higher values representing more favorable performance.

Plan ratings for each measure are based on the difference between the plan score and the unweighted group mean. The statistical significance of each difference is determined by computing a 95% confidence interval (CI) around it. If the lower limit of the CI exceeds zero then the plan score is significantly above the mean. If the upper limit of the CI is less than zero then the plan score is significantly below the mean. Plans with scores significantly above or below the mean at the 95% significance level usually received the highest and lowest designations respectively. All remaining plans received the middle designation.

The specific formula for calculating the CI for each measure is as follows:

For a given HEDIS measure or CAHPS individual question and plan k, let the difference d_k = plan k score – group mean. Then the formula for the 95% CI is $d_k \pm 1.96\sqrt{Var(d_k)}$

where $Var(d_k)$= Variance of d_k is estimated as

$$\frac{P(P-2)}{P^2} * \frac{p_k(1-p_k)}{n_k} + \frac{1}{P^2}\sum_{k=1}^{P}\frac{p_k(1-p_k)}{n_k}$$

and p_k = plan k score
P = total number of plans
n_k = the measure denominator for plan k

For a CAHPS composite, the variance formula is modified by substituting the plan composite global proportion variance ($CGPV_k$) for the $p_k(1-p_k)/n_k$ terms where

$$CGPV_k = \frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\bar{x}_j)}{n_j}\right)^2$$

and $j = 1,\ldots,m$ questions in the composite measure
$i = 1,\ldots,n_j$ members responding to question j
x_{ij} = response of member i to question j (0 or 1)
$\bar{x}_j$ = plan mean for question j
N = members responding to at least one question in the composite.

Alternatively, the CI formula can be rearranged to compute the test statistic $\frac{d_k^2}{Var(d_k)}$.

For $d_j > 0$, the lower limit of the CI is > 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

For $d_j < 0$, the upper limit of the CI is < 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

Comparing Rates Across Years

For determining the statistical significance of the trend in a plan score between 2003 and 2005, first compute the difference in plan scores between the two years. This difference *d* can be written as $p_{2005} - p_{2003}$ where p_{200x} is the plan score for year 200x on a given measure. Then compute a 95% CI around the difference. If the lower limit of the CI is greater than zero then the trend is significantly upward. If the upper limit of the CI is less than zero then the trend is significantly downward.

The formula for the CI around *d* is: $d \pm 1.96\sqrt{Var(d)}$

where $Var(d) = \hat{p}(1-\hat{p})\left(\frac{1}{n_{2003}} + \frac{1}{n_{2005}}\right)$

and $\hat{p} = \frac{p_{2003}n_{2003} + p_{2005}n_{2005}}{n_{2003} + n_{2005}}$

and n_{200x} is the measure denominator for year 200x.

APPENDIX C

METHODOLOGY FOR AUDIT OF HEDIS® 2005 RATES FOR MARYLAND HMOs & POS PLANS

METHODOLOGY FOR AUDIT OF HEDIS® 2005 RATES FOR MARYLAND HMOS & POS PLANS

HEDIS COMPLIANCE AUDIT™

The HEDIS Compliance Audit is a standardized methodology that enables organizations to make direct comparisons of plans' rates for HEDIS performance measures. The State of Maryland hired HealthcareData.com, LLC (HDC), an NCQA-Licensed Organization, to conduct a full audit of each of the Maryland commercial health plans in this report as prescribed by *HEDIS 2005, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*, published by NCQA. In addition, the HEDIS Compliance Auditor reviewed data MHCC required plans to report in 2005. A major objective of the Maryland audit is to determine the reasonableness and accuracy of how each plan collects and reports HEDIS data for performance reporting in Maryland. In addition to ensuring that the rates publicly reported are accurate and comparable, the audit also satisfies a requirement of health plan accreditation by NCQA. Each plan underwent an audit that met NCQA requirements.

The audit is primarily intended to examine how plans collect and report HEDIS data. HEDIS is a standardized set of key performance measures designed to allow purchasers and consumers to have the information they need to reliably compare the performance of managed care plans. By using a standardized methodology to collect the data and to calculate the measures, consumers, government agencies, employers and health plans themselves can more accurately evaluate and trend plan performance and make comparisons among plans. NCQA-Certified HEDIS Compliance auditors focused on two areas in each health plan, specifically: (1) an assessment of overall information systems capabilities; and (2) an evaluation of the health plan's ability to comply with HEDIS specifications for individual measures.

Audit Implementation

The audit process itself was divided into three phases: (1) audit preparation; (2) on-site visit; and (3) post on-site and reporting activities. During these three phases, auditors focused on a number of performance areas – including information practices and control procedures, sampling methods, data integrity, analytic file production, algorithmic compliance with measurement specifications, reporting and documentation. A detailed description of the well-defined phases of the audit appears in NCQA's *HEDIS 2005, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*.

Phase 1: Audit Preparation

The initial phase consisted of various supporting tasks or activities defined by NCQA. Activities performed included:

- providing the Baseline Assessment Tool (BAT) to health plans for completion;
- selecting mutually agreeable audit dates;
- certifying the CAHPS sample frame;
- reviewing the completed Baseline Assessment Tool;
- selecting core measures;
- finalizing the audit team;
- requesting source code for measures outside of pre-certified software;
- developing a detailed agenda for the on-site audit;
- reviewing various vendor operations and processes; and
- conducting a pre-visit conference call to discuss outstanding issues.

A key activity critical to the success of the audit was each plan's completion of the BAT in a timely manner prior to the on-site visit, plus a review of the completed tool by auditors and MHCC staff. The BAT is a comprehensive instrument designed by NCQA to collect information from the health plan regarding its structure, information collection and processing (e.g., claims/encounter processing, medical record review processes, membership data processes, provider data processes), and HEDIS reporting procedures (e.g., measure programming/determinations, reporting functions).

Auditors' also preformed the key task of selecting of a core set of measures for each plan. The protocol requires the minimum number of measures (13 in each core set) to be distributed across six HEDIS domains. As required, the core set can be expanded based on any findings or issues that surface during the on-site audit. Each auditor used a variety of criteria to select the core set, which includes but is not limited to the following:

- measures revised by NCQA from the prior year;
- new measures being reported;
- measures calculated by vendors or outside third parties;
- issues identified from review of the BAT that could impact code development;
- internal processes affecting data collection ; and
- problems experienced by the plan in prior audits.

Auditors utilized the core set as a means of evaluating all of the measures within the various HEDIS domains. Findings from their review were then extrapolated to the full set of HEDIS measures in making a final determination of their reportability. Only one Maryland plan used an NCQA-Certified software vendor to calculate its measures. All source code associated with the core set measure for the other six plans was reviewed by designated audit staff. The audit's core set also included all additional measures that MHCC required commercial HMOs to report in 2005.

Source code review for measures in the core set started during Phase One with initial review of the source code associated with the CAHPS sample frame programming.

Phase 2: On-Site Visit

During Phase 2 of the compliance audit, auditors conducted in-person interviews and record examination at the office of each plan. The on-site portion was composed of a number of critical activities falling into two broad categories: (1) an assessment of compliance with NCQA's standards for information systems capabilities; and (2) an evaluation of compliance with the HEDIS measure specifications.

(1) Information Systems (IS) Standards Assessment: During the IS assessment, auditors determined the impact of various IS practices on the HEDIS reporting process. The key to accurate reporting is collection of comprehensive and accurate data. The auditors did not attempt to evaluate the overall effectiveness of the health plan's management information systems. Rather, they determined whether the health plan's automated systems, information management practices, and data control procedures ensured that all information required for HEDIS reporting was adequately captured, translated, stored, analyzed, and reported.

The activities of auditors in this aspect of the audit consisted of the following:

- interviews of key plan representatives responsible for operations or departments supplying data used in HEDIS reporting;
- review of documentation relevant to the information system standards and, as needed, a demonstration of specific procedures;
- analysis of the documentation describing the operation of computer systems and computerized files via text, code, and flow charts;
- observation of operations which include those areas that use the information system resources while preparing data for the HEDIS report;
- verification that file contents were accurate;
- review of the oversight actions by the plan for all data received and transmitted; and
- evaluation of how data from the medical record review data abstraction process were integrated into the final measure calculations.

(2) HEDIS Measure Determination Standards: Each measure has a detailed set of specifications that describe both its purpose and method of calculation. In this activity, auditors determined whether the processes used to produce each HEDIS measure complied with these HEDIS specifications and yielded "reportable" results. If issues or discrepancies were identified, the health plan was given the opportunity to make corrections and resubmit corrected code until the auditors were satisfied that all specifications were met. In this audit component, auditors evaluated the following:

- identification of members for the eligible population (denominator) files, according to HEDIS specifications;
- determination of the extent to which sampling activities were performed according to HEDIS specifications;
- qualifying medical events (numerator) identification;
- determination of algorithmic compliance by ensuring that the computation of HEDIS rates or percentages, as well as other parameters, was done correctly;
- the documentation of data and processes;

- delegation and monitoring of activities performed by vendors; and
- assessment of software pre-certification results, as applicable.

Phase 3: Post On-Site and Reporting Activities

In Phase 3, auditors worked closely with plan representatives to ensure that they understood all unresolved issues and deficiencies as well as the potential effects of these issues and deficiencies on HEDIS data collection and reporting. When appropriate, additional questions were presented to each plan about plan software, programming, manual processing, data input and output, and the effect of significant events, such as system conversion. All corrective and follow-up action and reporting were centrally coordinated and documented. Each plan was also given a final review and the opportunity to correct any unresolved items before a final determination on reportability was issued for each HEDIS measure. Key activities accomplished during this phase were:

(1) Initial Report of Findings: Within 10 working days of the on-site visit, the audit team prepared an initial report on their visit. The report was returned to the health plan and included:

- a detailed listing of any outstanding issues;
- a listing of all materials/documentation not yet received;
- an assessment of whether each measure tested met specific data requirements;
- a listing of all problem areas that required follow-up action before the final audit report was issued;
- potential problems with measure rate integrity; and
- notes about any measures which, based on current findings to this point, would not be reportable should no further action be taken to correct identified deficiencies.

(2) Medical Record Review Validation: In this portion of the audit, the auditors completed their evaluation of the health plan's medical record review and process. The auditor began by reviewing all training materials and internal oversight policies established by the plan for medical record review. Then the auditor verified the accuracy of the health plan's findings in which a numerator positive event was identified; i.e., the plan's reviewer determined whether or not the criteria for the measure were met and the designated medical service was delivered. Each auditor selected three measures for each plan and requested 35 charts for each measure. In the event a plan did not have 35 numerator positives the auditor examined records to validate numerator negatives up to the level of 35 records.

(3) DST Review: The Data Submission Tool (DST) is used by the health plan to electronically record all HEDIS results and calculations that are submitted to NCQA and MHCC. Maryland-specific data were submitted on an MHCC-specific DST. The DST review consisted of two phases. First, the plan submitted the results to NCQA where the data are subjected to a series of rules and guidelines that helped to identify potential problem areas for correction. After passing this level of review, the health plan sent the DST to its auditor for review. The auditor compared the plan's results to established NCQA benchmarks and compared the plan's results with its rates from the previous year. Rates that varied by 10% or more between years were flagged, as were rates below the

10th and above the 90th percentiles in comparison to NCQA benchmarks. Problems detected by the auditors were evaluated to determine whether additional analysis and review were necessary.

(4) Audit Designations: After reviewing all relevant documentation and processes, the auditor issued a designation of *Report* or *Not Report* for each measure included in the audit. Determination for each measure was based upon the rationales described here.

Report (R)

"Report" designation indicates the measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate. Under NCQA guidelines, it is possible for subcomponents of a measure to fail the audit and be designated "Not Report (NR)," without resulting in an NR rating for the entire measure. An example of this is the Ambulatory Care measure that is composed of 4 subcategories: outpatient visits, emergency room visits, ambulatory surgery, and observation room stays. One of these subcategories could be designated NR, but the measure, being a composite of 3 other reportable subcategories, would be deemed as "R" (Report). A measure designation of "Report" may also be assigned where the denominator for the measure was too small to report a valid rate or where the plan did not offer a health benefit for the measure being reported. In these cases, the rate is designated in the Maryland publications as "**NA" (Not Applicable)** and the measure is "Reportable" with that designation.

Not Report (NR)

In compliance with guidelines established by the State of Maryland, the "Not Report" designation for a measure indicates that the rate submitted by the plan did not pass the audit. In other words, the auditor determined that the results produced by the plan were significantly biased and therefore not reflective of the plan's true performance. NCQA has broader categories for the "NR" designation, **but in Maryland health plans cannot voluntarily choose to accept an "NR" designation in place of a rate. Health plans are required to calculate and report all HEDIS® measures that are part of the state's mandated performance reporting process unless the measure is designated as "Not Report" by the auditor.**

(5) Audit Findings: HDC summarized its audit findings in a plan-specific Final Audit Report that was submitted to the plans and to MHCC. The report included recommendations for improvement and change in future audits.

APPENDIX D

METHODOLOGY FOR ADMINISTERING CAHPS® 3.0H SURVEY FOR MARYLAND HMOs & POS PLANS

METHODOLOGY FOR ADMINISTERING CAHPS® 3.0H SURVEY FOR MARYLAND HMOS & POS PLANS

Background

The survey instrument and procedures employed in 2005 to obtain information about member satisfaction is the Consumer Assessment of Healthcare Providers and Systems questionnaire and protocol (CAHPS®). CAHPS originally stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the name has changed to capture the full range of survey products and tools. MHCC contracted with The Myers Group, a survey company specializing in health care and other consumer satisfaction surveys, and an NCQA-Certified survey vendor, to conduct the research following standard CAHPS procedures. In addition, MHCC contracted with the NCQA-licensed audit firm, HealthcareData.com, to review any programming code used to create the list of eligible members for the survey, plus validate the integrity of the sample frame before the certified survey vendor draws the sample and administers the survey. Survey data collection began in early February 2005 and lasted into May 2005. Summary-level data files generated by NCQA were distributed in June to each of the plans to allow review of data prior to signing attestations.

Sample sizes remained stable in 2005 based on analysis of 2004 data. The sample size is set to achieve the minimum number (411) of completed surveys necessary to obtain reportable results.

In total, the Maryland core CAHPS survey consists of 64 questions—8 of which are Maryland specific questions. The core of the CAHPS survey is a set of 10 measures that are used to understand satisfaction with the experience of care. These include 4 ratings questions that reflect overall satisfaction and 6 "composites" that summarize responses in key areas.

The ratings items ask the respondent to rate their doctor, specialist, experience with all care, and their health plan on a 0 to 10 scale. Responses are also summarized into categories. The top category summarizes those that choose a 9 or 10 rating. The second category summarizes those that choose a 7 or 8 rating. For example, all respondents that choose to rate their physician 9 or 10 would be counted as belonging to the top category, those respondents rating their physician a 7 or 8 would be counted as belonging to the second category.

There are six composite scores that are generated from the individual respondent level data. The six composite scores are: claims processing, courteous and helpful office staff; customer service; getting care quickly; getting needed care; and how well doctors communicate.

Survey Methods and Procedures

Sampling: Eligibility and Selection Procedures

The health plan members who were eligible for participation in the CAHPS 3.0H adult commercial survey had to be 18 years of age or older as of December 31 of the measurement year (2004). They also had to be continuously enrolled in the commercial plan for at least 11 of the last 12 months of 2004 and still enrolled in the plan in 2005. The data sets submitted to the CAHPS vendor are sets of all eligible members – the relevant population. All health plans were required to have their CAHPS data sets (sample frame) audited by the licensed HEDIS auditor prior to sending to the survey vendor.

After The Myers Group received and checked the population sample from the plans, the files were deduplicated to assure that no more than one member of a household would be selected for participation. Members were then randomly selected for participation. The standard sample size for 2005 administration (2004 measurement year) was 1,100.

In order to reach the maximum number of selected members, the sample files were sent to a National Change of Address (NCOA) look up and telephone matching service. Updated addresses and phone numbers were merged into the sample files.

Survey Protocol

The CAHPS survey protocol used to generate the data summarized in this report uses a rigorous, multi-stage contact protocol. The protocol features a mixed-mode methodology that consists of a four-wave mail (two questionnaires and two reminder postcards) with telephone follow-up of at least six telephone attempts. This protocol is designed both to maximize response rates and to give different types of responders a chance to reply to the survey in a way that they find comfortable. For example, telephone responders are more likely to be younger, male, and healthier. Mail responders are more likely to be older, better educated, and less healthy. The option for a mail-only methodology was available but MHCC chose to use the mixed-mode methodology.

Response Rates

As directed by NCQA, the response rate is calculated by dividing the number of completed surveys by the number in the original sample, minus the ineligible respondents (completes/total sample - ineligibles). A survey is classified as a valid completion if the member appropriately responds to Question 1 and answers at least 80% of the survey questions (not including the Medical Assistance With Smoking Cessation or custom questions). Ineligible respondents are those that are no longer enrolled in the health plan, cannot respond to the survey in the language in which it is administered, are deceased, or are mentally or physically incapacitated.

There is no minimum required response rate; however, there is required minimum of a denominator of 100 to achieve a reportable rate. In 2005, the response rate of the seven plans was 36.59% compared to 38.98% in 2004. For 2005, the highest response rate was 45.54% and the lowest response rate was 32.38%.